H.R. 505—THE OLDER VETERANS' HEALTH CARE AMENDMENTS OF 1985

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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H.R. 505—THE OLDER VETERANS' HEALTH CARE AMENDMENTS OF 1985

THURSDAY, APRIL 25, 1985

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Mollohan, Penny, Daschle, Hammerschmidt and McEwen.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. EDGAR. Good morning. The subcommittee will come to order.

The purpose of this morning's hearing is to receive testimony on H.R. 505, the "Older Veterans' Health Care Amendments of 1985." This legislation is designed to assure the equitable and efficient provision of health care services, particularly extended care services, to older veterans.

On Tuesday, this subcommittee held a joint hearing with the House Select Committee on Aging. It was a lengthy hearing and we heard a lot about medical care for the aging in and outside the VA. On one hand, I was particularly pleased to hear that the VA is a respected organization in the field of academic geriatrics and planning to meet the needs of older veterans. However, I continue to be dismayed that there are real gaps in the services offered by the VA, especially with respect to long-term care. Of course, the issues we discussed on Tuesday with respect to coordination between the VA and other Federal health care programs are of very great concern. The unwillingness of some branches of the administration to even come to talk to us is a serious indication of their trying to avoid these problems.

The legislation that I have introduced, which is the subject of this hearing, is designed to partly solve some of the gaps in VA services. I pledge my continued efforts toward the end of giving our aging veterans the kind of health care they deserve in the cost-effective way that is required of good government.

Specifically, H.R. 505 would provide respite care to veterans suffering from terminal illness. I believe that clarifying the VA's authority to provide such care when medically indicated will result in allowing veterans to remain longer in their homes with the comfort of their families. It will also result in freeing more acute and

intermediate care beds that are now occupied by terminally ill patients who could be cared for in their homes if some relief for their caregivers is available.

This legislation would also amend existing provisions governing the admission of veterans to VA domiciliaries. Current rules for admission to domiciliaries for veterans with service-connected disabilities are inconsistent with the priority given such veterans in other types of VA health care. This provision would eliminate disparate treatment afforded to service-connected disabled veterans.

Another provision of H.R. 505 would modify eligibility for outpatient treatment and would enable the VA to treat more veterans in nursing home care units and domiciliaries without adding beds to the VA system. At the present time, certain veterans are retained as patients in VA nursing homes and domiciliaries because they require followup medical treatment and are not discharged because they are not presently eligible for outpatient treatment.

The difficulties in admission to VA nursing homes were amply described during Tuesday's hearing. H.R. 505 would help to alleviate these problems by permitting transfers from VA nursing home care units and domiciliaries to community nursing homes. Present law requires that a veteran must be discharged from VA hospital care in order to be transferred to a community nursing home at VA expense. This encourages unnecessary hospital admissions because the physician who believes that a patient should be cared for in a community nursing home can only arrange such treatment by first admitting the patient to a costly hospital bed before transfer to a community nursing home.

A similar practice of admitting patients to a VA hospital who are being treated at home through the VA's hospital-based home care program in order to make them eligible for community nursing home treatment would also be eliminated by this legislation. Additionally, it would permit veterans who require nursing home care for treatment of a service-connected disability to get such care without the administrative burden of reauthorizing such care every 6 months. This legislation also authorizes the VA to make per diem payments to States providing intermediate nursing care to veterans being cared for in State nursing homes.

H.R. 505 would authorize an expansion of the VA's successful program of encouraging clinical treatment of and research into diseases affecting older veterans. This program, known as the Geriatric Research, Education, and Clinical Center Program, was formally established by Congress in Public Law 96-330. At present, there are 10 such programs which are fine examples of how the Government can examine the needs of veterans today in order to provide better treatment for veterans in the future. H.R. 505 would encourage the VA to continue to expand this program by authorizing 25 such programs instead of the present limit of 15.

The president of the Blinded Veterans Association, Mr. Thomas Miller, has submitted a statement for inclusion in the record. Without objection, it is so ordered.

[The statement of Thomas Miller appears at p. 35.]

Mr. EDGAR. I will now recognize the ranking minority member of the subcommittee, Hon. John Paul Hammerschmidt, for any remarks he may want to make.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

This hearing today illustrates again our subcommittee's concern with problems facing the aging veteran. Mr. Chairman, your bill, H.R. 505, is an excellent but modest approach to solving some of these problems. It is noted that in his testimony to be heard later this morning, Dr. John Mather, speaking for the Veterans' Administration, is in essential agreement with much of the central thrust of the bill, as are the representatives of the various veterans organizations.

Mr. Chairman, the respite provision of H.R. 505 is worthy of particular note. It codifies into law a comparatively new aspect of medical care for veterans. It is a compassionate and good medical extension of hospital-based home care. Mr. Chairman, the VA's suggestion to use respite care for the chronically ill, and not just the terminally ill, seems to me to be a good one, as does the suggestion to have a 3-year pilot program. However, inasmuch as dollars and good medical judgment will control the program, and inasmuch as it would be limited by its very nature, I feel it is not necessary to curtail its scope as recommended by the Veterans' Administration.

Mr. Chairman, I feel that the idea of respite care for veterans and their families is an exciting new prospect for the VA Medical Program. I am confident that we can work out the details of a final legislative proposal.

The remainder of H.R. 505 has merit. It concerns service-connected veterans' eligibility for domiciliary care, outpatient treatment following VA nursing home or domiciliary care, community nursing home care eligibility, and clarification of existing law as to service-connected veterans being entitled to unlimited contract nursing care.

The proposal to expand authorization for GRECC's from 15 to 25 is just a matter of when the Congress will act on such authorization. GRECC's currently are 10 in number, even though authority exists for 15. Appropriations control the establishment of these Geriatric Research, Education and Clinical Centers, and if we authorize 25, as indeed we should, at some point in time the appropriations process is still the vehicle for their actual establishment. Moreover, we should recall that the VA aging report called for such an increase as one method of meeting future requirements for good medical care for aging veterans.

Mr. Chairman, H.R. 505 merits our careful consideration. I congratulate you for scheduling this hearing on it.

Let me say there is a Republican conference that started at 9:30, which accounts for the absence of our Members, and I, myself, must leave. I didn't want to ask for a postponement of this very important hearing because I do think you want to make your record as early as you can. I am going to go over to that conference and try to return, but I see we have enough Members for you to continue on with the hearing.

I would ask that we be allowed to submit questions for the record.

Mr. EDGAR. Without objection, we will hold the record open for questions. I do appreciate your coming over here this morning.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Mr. EDGAR. Are there any other opening statements or comments that my colleagues would like to make? Let me then call our first witness this morning, Dr. John Mather, Assistant Chief Medical Director for Geriatrics and Extended Care in the Veterans' Administration. It is good to have you here this morning.

If you will introduce the person that you have with you and proceed, the full text of your statement will be made a part of the record.

STATEMENT OF JOHN H. MATHER, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR GERIATRICS AND EXTENDED CARE, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION; ACCOMPANIED BY RALPH IBSON, DEPUTY ASSISTANT GENERAL COUNSEL, VETERANS' ADMINISTRATION

Dr. MATHER. Thank you, Mr. Chairman. I have with me Mr. Ralph Ibson from the General Counsel's Office.

I am pleased to have the opportunity to present the views of the Veterans' Administration on H.R. 505. As you have indicated, I do respectfully request that the full text of my remarks be introduced in the record.

Mr. EDGAR. Without objection.

Dr. MATHER. In summary, with the deletion of section 6 of the bill, which would authorize expansion of the GRECC program, and revision of the bill's respite care provisions, we would totally favor the enactment of H.R. 505. A bill revised along these lines would greatly assist the VA in managing the care of aging, chronically ill patients already in VA medical programs. The Veterans' Administration could implement such a revised bill without incurring significant additional costs.

Section 2 of H.R. 505 would permit the VA to furnish "respite care" to veterans currently eligible for VA hospital or nursing home care. The bill defines respite care to mean hospital or nursing home care provided in a VA facility on an intermittent or temporary basis to a veteran who has been diagnosed as suffering from a terminal illness and who is receiving care in the individual's home or in a hospice program under contract with the VA.

This provision is troublesome in limiting respite care to the terminally ill. We believe that the authority to furnish respite care to chronically ill veterans could prove a useful means for avoiding or delaying prolonged, costly institutionalization. Limiting the scope of this provision to veterans whose illnesses are terminal, however, would seem to be unwarranted from a medical and social perspective.

We believe the development of new VA health care programs is best approached on an experimental basis. Thus, we recommend that Congress enact legislation to authorize the VA to provide respite care on a 3-year pilot test basis for those chronically ill veterans who have the highest claim to VA services—that is, service-

connected disabled veterans. This pilot test, using existing funds, would include an evaluation to determine whether or not the program should be continued. We recently submitted a legislative proposal to the committee to provide such respite care authority and we urge you adopt our proposal.

We would like to express our appreciation to the chairman for introducing this proposal as H.R. 2179 the day before yesterday.

Section 3 of the bill would establish a single standard of eligibility for domiciliary care. We favor this provision and its enactment would not result in additional costs.

Section 4 of the bill would authorize VA to provide limited outpatient treatment to veterans discharged from VA nursing homes and domiciliaries. We favor the enactment of this provision because it would permit a more rational system for appropriately meeting our patients' medical needs. Not only would this provision help veterans make the transition from institutional to community placement, it would also result in better utilization of facilities.

Section 5 of the bill proposes a series of amendments to section 620 of title 38, under which VA administers the Community Nursing Home Care Program. We favor the enactment of section 5. In general, it would improve our capability to provide patients with the most appropriate treatment.

The section specifically would, No. 1, clarify the VA's authority to transfer patients from VA nursing home care units and domiciliaries to community nursing homes. Two, it would provide an exception for veterans requiring nursing care for a service-connected condition to the 6-month limitation on the duration of VA-sponsored nursing home care. Three, it would authorize the VA to admit directly into a contract nursing home for care any veteran who has been discharged from a VA hospital and who is a patient in a VA hospital based home care program. And fourth, it would permit the VA to make per diem payments under section 641 to States providing intermediate nursing care at the same rate as for skilled nursing care.

We particularly favor the proposed amendment of section 620(e), which seeks to resolve an issue regarding VA per diem payments under 38 U.S.C., paragraph 641, to States providing nursing home care in State homes. Section 641 contains a single per diem rate for payment of nursing home care furnished eligible veterans in State veterans homes.

Some States with State veterans homes recognized by the VA for nursing home care have obtained Medicare certification as a skilled nursing facility, or Medicaid certification as a skilled or intermediate care facility, or both. The two terms "skilled nursing facility" and "skilled nursing care" are not synonymous. We believe this technical amendment such as is proposed in section 5 would resolve this matter; thus, we favor this proposal.

Section 6 of the bill would authorize an expansion of the geriatric research, education, and clinical centers, or GRECC, program to 25 centers. The VA currently operates 10 GRECC's. We foresee no need at this time for additional legislative authority for this program and do not favor enactment of section 6.

That concludes my statement, Mr. Chairman. I will be pleased to answer any questions you or members of the subcommittee may have.

[The statement of Dr. John Mather appears at p. 27.]

Mr. EDGAR. Thank you very much. We appreciate the comprehensive nature of your statement on the legislation.

Were you here the other day?

Dr. MATHER. Yes, Mr. Chairman.

Mr. EDGAR. Did you bring any data with you about the subject we were talking about the other day?

Dr. MATHER. Mr. Chairman, I'm not sure I recall what we were talking about, the "needed" data. [Laughter.]

Mr. EDGAR. I'm just teasing.

I wonder if you might speculate, from your experience, as to whether or not there are any additional amendments that you would suggest, apart from your testimony or highlighted in your testimony, that could aid you in trying to focus on the issue of the aging veteran. Is there something we neglected in this legislation or an area of concern that you would like highlighted that is not part of the legislation at this point?

Dr. MATHER. Mr. Chairman, within the scope of this hearing and the concerns of H.R. 505, I think the bill is comprehensive in regard to the areas that it addresses. We continue to study within the agency various aspects of meeting our veteran "geriatric imperative" and some of the proposals that have been forthcoming in the aging report are under active study. These studies relate to items that might need to be eventually forthcoming as legislative proposals.

One item that has, I think, in previous hearings been mentioned is having authority comparable to hospital-based home care, that is a contract variety for home health care.

Mr. EDGAR. Which is not included in the legislation at this point.

Dr. MATHER. That's correct, Mr. Chairman.

Mr. EDGAR. Mr. Penny, do you have any questions?

Mr. PENNY. No. I was really pleased and surprised at the testimony which is summed up in the first two sentences, that with the deletion of section 6 and the revision of the respite care provision they are going to support the bill. It's just nice news.

Mr. EDGAR. It's nice to have some support, isn't it?

Mr. PENNY. Yes. I don't expect that we're going to hear any strong reservations on the legislation from the folks who will be following, so this is a delightful hearing.

Mr. EDGAR. Dr. Mather, we have an estimate of the cost from CBO that this bill would only cost approximately $5 million in fiscal year 1986. This is almost entirely due to the provision authorizing direct transfer of patients from VA nursing homes and domiciliaries to community nursing homes.

Would you estimate, from your experience, that that $5 million estimate sounds appropriate?

Dr. MATHER. Mr. Chairman, not being privy to the assumptions in the CBO estimate, I am not sure that we even have to consider any dollar figure concerning this piece of legislation. I think what we have attempted to recognize in this bill is that we're trying to eliminate barriers to the appropriate flow of patients or the trans-

fer of patients that need care, and not to continue any subterfuges through readmitting to hospitals patients from a nursing home or hospital-based home care.

I am not certain, from our perspective, that there are really any additional costs involved in this particular bill, and we have so testified.

Mr. EDGAR. If there is no cost to this bill, and no savings in the other two provisions we talked about the other day, pretty soon we will be giving money back to the Federal Government—OK. [Laughter.]

Dr. Mather, the VA has proposed legislation similar to section 2 of H.R. 505 to authorize respite care. However, your proposal would limit respite care to veterans being cared for in their homes, whereas H.R. 505 would also permit respite care as part of a hospice program.

Since a hospice program may involve care at home as well as care in a hospice facility, wouldn't it make sense to encourage cooperative arrangements between these programs and the VA hospitals by making veterans eligible for admission to a VA hospital if such an arrangement exists?

Dr. MATHER. Mr. Chairman, I think from our perspective the hospice program is really in a state of evolution. We have had, and as was reported about a year ago in the New England Journal of Medicine, the results of the 3-year pilot study that we conducted at the Wadsworth VA Medical Center. In that particular hospice program, which was a combination of an inpatient palliative care unit and a home health care component, including bereavement counseling for the families, we were able to establish that for the same amount of money that might be used for terminally ill patients elsewhere in that facility, we were able to configure a hospice program that actually for the same dollars and FTE, was shown to be more cost effective.

The extent to which respite care is an explicit component of a hospice program, it is really more implicit than explicit. Hence, we feel that we need a broad respite care authority for the chronically ill, from a programmatic standpoint.

I would like to add that we have been charged by the Senate Veterans' Affairs Committee to report to them later this year on our studies of hospice activities going on in the agency. We are presently well into completing that study. I think it will also highlight this particular point, that hospice is a program with implicit respite care characteristics.

Mr. EDGAR. You recommended in your testimony that this committee consider establishing a respite care authority on a 3-year pilot test basis. This pilot would include an evaluation component to determine whether or not the program should be continued.

In the 98th Congress a pilot authority with an evaluation component was provided for adult day health care. Will you describe briefly the status of that pilot program and what we might anticipate if the respite authority were similarly made a pilot effort?

Dr. MATHER. Mr. Chairman, we do have specific difficulties with initiating a pilot program to study the efficacy of the adult day health care program, for essentially two reasons. First of all, we have only been able to secure sufficient funds to establish five VA-

operated adult day health care programs. Hence, we cannot do one part of that study that was required. It was to compare the cost benefits of doing it ourselves or doing it under contract.

The second aspect of that study that was required was to compare similar patients as to whether it is more cost effective to put them in adult day health care or into a nursing home environment. We believe at this point in time we have an insufficient number of adult day health care programs established to be able to initiate this particular study.

Mr. EDGAR. As defined in H.R. 505, the term "respite care" means hospital care or nursing home care furnished on an intermittent or temporary basis. In the VA's version, the term appears to mean of limited duration. How do you define "limited duration"?

Dr. MATHER. We have found, Mr. Chairman, that as we have studied respite care as a broad program activity in this country, the average stay is 1 to 2 weeks as a definitive and planned respite care admission. We find that this meets the needs of intense targeted rehabilitation for that admission, and also the required time for the primary care giver, usually a spouse, to receive the respite that is the main characteristic of this program.

Mr. EDGAR. Let me turn to another issue.

What are your estimates about the number of veterans who require readmission to VA hospitals in order to be placed in community homes at VA expense each year?

Dr. MATHER. Mr. Chairman, I have no hard and fast estimate, but we do know it is a practice that goes on. To the extent we have been able to glean anecdotal evidence, I would say it happens no more than 5 percent of those that actually are in community nursing homes.

Mr. EDGAR. Let me just go back to the respite care issue for a minute.

In your testimony you suggest that the respite care being provided should go to chronically ill veterans rather than just terminally ill veterans. Could you explain the reasoning for that change?

Dr. MATHER. We think to have the broader authority is consistent with those that are at home under the care of their spouses, who are not just terminally ill but, have major long-term, chronic problems. They may have several medical diagnoses and certainly significant limitations on their activities of daily living, dressing, and so forth. To limit the authority to the terminally ill would belie the broader efficacy and value of respite care.

Mr. EDGAR. With regard to the 6-month limit on nursing home care for non-service-connected conditions, under what general conditions are extensions of the 6-month limit usually made?

Dr. MATHER. There are commonly two reasons, of which the first one is the primary reason. First, it is the inability to transfer that individual to other sources of funding—usually, in our instance, Medicaid. We have many States that have provisions that preclude us from submitting a request for transfer to Medicaid funding until such time as their primary benefit, which in this instance would be a VA benefit, is essentially exhausted.

Second, we have instances in which we have strong humanitarian reasons for retaining that person in that community nursing

home for a short extended period of time. The family has not quite been able to make the final arrangements. For example, somebody with Alzheimer's disease constitutes a significant medical and social problem.

Mr. EDGAR. Let me go to a final question.

We have a provision in this bill to change the number of GRECC's from 15 to 25 that are authorized, and as John Paul Hammerschmidt indicated in his statement, it would then be up to the Appropriations Committee and the Budget Committee to come up with sufficient funds for 25 geriatric research centers.

In your opinion, would they be useful in fostering the increased coordination between the VA and other health-care programs that several witnesses have encouraged us to do in their testimony today, as well as on Tuesday?

Dr. MATHER. Mr. Chairman, I think the track record of the 10 existing GRECC's, particularly the original eight that got underway in 1975, is improving in working with their hosting VA medical center to reach out to the community at large. We have very clear evidences, particular at the GRECC in Boston from which you heard Dr. Jack Rowe on Tuesday, some of the significant efforts that have gone on in this regard.

Mr. EDGAR. I wonder, in conclusion, in light of the releasing of the aging report which came out late on a Friday afternoon in September, and the controversy that is swirling around the issue of more need and yet less dollars available to provide service for the aging veteran, if you could evaluate whether or not the VA budget, in an effort to respond to the problems of the aging veteran, will be adequate next year and over the next 5 years?

Dr. MATHER. Mr. Chairman, I really do not care to speculate on those items that refer essentially to issues of budget and appropriation. I think the extent to which the aging report represents a statement of philosophy and principles, I have heard from no one to date that fundamentally objects to those principles incorporated into that report.

There are two major thrusts that I think have been clearly recognized in need of broader development. One was the issue of working toward better establishment of our noninstitutional or ambulatory varieties of long-term care—including hospital-based home care, adult day health care, and such like. Second, I think the whole area of interaction with the community, commonly referred to as "community collaboration," is in need of greater fostering.

In this regard, I think we have seen, not just because of the aging report but also the manuscript prepared by Dr. Jack Rowe's office, Harvard Medical School, Division of Aging, clear indications of ways in which we can engage in better collaboration with the community at large.

I think we are very careful to recognize that the authorities the agency has right now to engage in a broad-based way with the community at large needs careful scrutiny. We are actively working with the general counsel to establish these particular mechanisms, and determine those aspects of our legislation that might inhibit or preclude us in any way.

Mr. EDGAR. I'm not sure I understand the last sentence. Why couldn't Harry Walters issue a directive, or in one of his teleconfer-

ences with the regional directors and hospital directors across the country, simply indicate that it will be the mission of the Veterans' Administration, starting May 1, to sit down and learn from the community and the community social workers what resources are in the community and to interpret the VA's resources as they relate to the aging veteran to community social workers and activists, so that better coordination could begin starting day 1? Why do you have to wait for legal opinion and other efforts?

Dr. MATHER. Mr. Chairman, I appreciate the opportunity to clarify my last few remarks, but let me come to that in a moment.

I think it is clear that we are not waiting around to engage in those kinds of discourses. We know that those kinds of discussions are going on in the communities. It has been a key aspect of the requirement in the MEDIPP process for the past 2 years to actively engage in these discussions. I think we can clearly, in certain programs like adult day health care where we have the authority to engage in quid pro quo arrangements, immediately achieve progress.

I think there is a broader aspect to this, though, which has a legal connotation. For instance, in the sharing law it states very clearly that we can only share on the basis of a specialized medical resource. We are presently working with general counsel to try and establish what the interpretation really should be, whether there might need to be a greater attention to that with a broadening of that authority and not limit it, per se, to specialized medical resources.

I can assure you, Mr. Chairman, these matters are under active discussion in order to confirm a number of initiatives that we have received from the field, that really can be implemented forthwith.

Mr. EDGAR. Where are they being done well?

Dr. MATHER. The kinds of interactions that are being done well I think are where we have the involvement of at least not just the VA medical center but the planners in the various districts. I would specifically point to Boston, where the planner in the VA and at least three VA medical centers involved in that particular primary service area have active dialog with the health systems agency and with the area agency on aging. In Florida at this point in time the Gainsville Medical Center continuing to develop with the State unit on aging a project called Project Teach. I could go on down a whole litany of proposed programs.

All of them have different flavors and all of them, I am pleased to say, have different aspects of innovation and creativity.

Mr. EDGAR. It would be helpful for the record if you could just provide us with 5 or 10 specific examples from around the country that could add to our record, those areas that you believe are really responding to this whole question of better communication in the community as well as the VA.

Dr. MATHER. We will be pleased to do that, Mr. Chairman.

[The requested information follows:]

Subsequently, the Veterans Administration provided the following;

EXAMPLES OF VA INVOLVEMENT IN COLLABORATIVE EFFORTS WITH THE COMMUNITY

1. Under the Community Nursing Home Program, the Veterans Administration contracts with over 3,200 nursing homes throughout the nation for the care of aproximately 40,000 veterans (FY 1985). In addition to the current annual budget of $253 million paid to these nursing homes, VA provides consultation and, frequently, in-service training to the staff of many of these homes in an effort to maintain and enhance the quality of care provided, particularly to veterans, but ultimately to all patients.

2. The Community Residential Care Program (CRCP) maintains an average daily census of approximately 12,800 veterans in over 3,100 homes in 49 states. While veterans in this program pay for the cost of care from their own incomes, the VA provides extensive consultation and training to the operators and staff of these homes to enhance the quality of care and the quality of life provided to all residents of the homes.

3. All VA medical centers have an Information and Referral Program in which information about services and benefits is exchanged with the network of community agencies, particularly the Area Agencies on Aging, resulting in a greater volume of appropriate referrals from the VA to the community and vice-versa.

4. Nationally, the Department of Medicine and Surgery is working with the Administration on Aging (AoA) to develop an agreement for jointly sponsored demonstrations for VA/AoA collaboration. These projects would focus on (1) providing specific services to caregivers and patients with Alzeheimer's disease; (2) developing new, community based treatment alternatives; (3) developing effective models of collaborative case management to produce optimal use of community resources; and (4) developing collaborative education programs for the clinical staffs of the VA system and the aging network.

5. Professional and technical assistance (short of providing direct services to non-veterans) is provided to community agencies in the creation or development of health or health support services to meet the needs of the community, with particular emphasis on the needs of the elderly. It is not possible to specify the extent of such endeavors because information on VA/non-VA collaborative projects is not routinely collected by VA Central Office at this time. However, there are indications that examples, similar to those cited below, are in operation at many VA medical centers throughout the system.

(a) Cleveland VA Medical Center staff played a major role in stimulating and assisting the development of a consortium on protective services for the elderly, providing education and training of public groups and agencies (e.g., police department) to control abuses of the elderly. This group sought and was granted support funding from a private foundation.

(b) The same medical center has also provided professional/technical assistance in the community development of a project to provide emergency shelter for adults. The first shelter has recently opened. Some funding for this project is also provided in a grant from a private foundation.

(c) At least two VA medical centers (Hines, Illinois, and Miami, Florida) have stimulated and assisted community efforts to provide emergency medical electronic alert systems (such as Life Line) to serve both veterans and non-veterans.

(d) VA Medical Center, Gainesville, Florida, has initiated a project involving several community agencies to train volunteers to provide respite care in the home to the caretakers of infirm veterans and non-veterans. The project plans to open a community Adult day Health Care Center in the future.

(e) VA medical center in the Boston area provided professional assistance to the Massachusetts General Hospital in developing that hospital's Foster Care Program for medically infirm patients from the community.

(f) The Loma Linda VA Medical Center has organized a community consortium, now incorporated, to provide support services to relieve the family burden of caring for patients with Alzeheimer's disease. A community adult Day Health Center for this group is planned.

6. Except under certain, restrictive circumstances the VA legislative mandate does not permit the agency to provide direct services to non-veterans on a collaborative basis. One exception to this is the authority, provided in Public Law 98–160, to enter under contract into collaborative arrangements with community entities to provide Adult Day Health Care to veterans and non-veterans alike. An example of this kind of collaboration is at the VA Medical Center, Hines, Illinois, where the hospital has entered into a collaborative arrangement with the Proviso Township Council on Aging with support from private foundations to form an Adult Day Health Care Center. The VA's contribution to this endeavor initially consisted of

professional/technical assistance and guidance in forming the consortium and in obtaining grant funds. It now consists of 1.5 FTEE direct care staff, who provide clinical services in the center to veterans and non-veterans alike.

Mr. EDGAR. Are there any additional questions? Minority Counsel has some questions.

Mr. WILSON. Dr. Mather, could you tell us why the domiciliary program demand has been declining over the years to its current status?

Dr. MATHER. This phenomenon has been a matter for considerable speculation in our office. We know there are some temporary measures that resulted in this situation. For instance, buildings which really have deterioriated into such a state of disrepair that we have had to close them down.

That doesn't explain, though, on the other hand, the continuing decline in census.

Mr. WILSON. Has there not been a lowering of demand or applications?

Dr. MATHER. It is not clear whether there has been a reduction in applications or whether we're just doing a better job of assessing whether the individual really ought to stay in that domiciliary. As of 2 years ago, we reemphasized that the mission of the domiciliary is more in the nature of a rehabilitation program rather than just itinerant housing. What we have seen, though, in the past year—and this is not reflected in any published data—is a change, in fact, in the census. The census has turned back up within the past year.

I think there are a number of reasons for that, none the least of which is that we're finding the domiciliary program can be used for those patients who need to be in an institutional setting but do not specifically need to be in a nursing home. They are ambulatory, they're in wheelchairs, or what have you. So I think we have begun to see the change in that program back onto a more positive footing.

Mr. WILSON. Doctor, just one additional question, and then, as Mr. Hammerschmidt said, we will submit the rest of them for the record.

Could you tell us what this bill does specifically to increase the benefits for disabled veterans who are service-connected in terms of domiciliary admission?

Dr. MATHER. I would be happy to provide specific information, but I would ask Mr. Ibson to give the technicalities of that answer.

Mr. IBSON. Mr. Wilson, the bill eliminates a series of very technical requirements applicable only to service-connected veterans, and establishes a very straightforward, simple test of need for domiciliary care on the basis of inability to defray. Of course, section 622 of title 38 clearly establishes the fact that a veteran is service-connected establishes him, per se, as being unable to defray, for purposes of eligibility for domiciliary care.

Mr. WILSON. Thank you, Mr. Chairman.

Mr. EDGAR. Are there any additional questions?

Dr. MATHER. I appreciate the opportunity, Mr. Chairman.

Mr. EDGAR. Thank you for coming this morning.

Mr. EDGAR. Our next witness will be the national commander of the Veterans of World War I of the United States. Mr. Pavlik, we are pleased to have you here this morning.

STATEMENT OF JOHN PAVLIK, NATIONAL COMMANDER, VETERANS OF WORLD WAR I OF THE U.S.A., INC.

Mr. PAVLIK. Thank you.

I have a prepared speech here that I would like to present. It is rather short.

Mr. EDGAR. Very good. Please proceed.

Mr. PAVLIK. First of all I want to say good morning to you gentlemen.

Mr. Chairman and members of this distinguished committee, we are pleased to have the privilege of presenting to you the thinking and feelings of the Veterans of World War I, the "old soldiers of 1917-18," with regards to older veterans health care issues.

Most projections prepared dealing with the older veterans make projections to the year 2000. With our current average age of 89 today, in the year 2000 the veterans of World War I who are still living will be 104-plus. Time is of essence for our buddies.

As the national commander of the Veterans of World War I, I present our wish for the Veterans' Administration to develop or support noninstitutional, long-term care service, based on VA facilities, home and community programs. We would like to see programs for the establishment of geriatric evaluation units in the system's hospitals and the increase of VA-provided or supported inpatient bed capacity.

More specifically, we would like to see the reinstatement of VA medical programs wherein, due to transportation problems of our aging veterans, the veterans are treated in their own home town by their own long-time physicians, who have taken a personal and professional interest in not only the veterans but also the welfare of the veteran's family, and the reimbursement for medications obtained at their own local drug stores.

When our veterans developed seeing problems, the VA fitted the veteran with glasses. When his hearing failed, he was fitted for a hearing aid. Now that the World War I veteran's teeth are in need of special attention, consideration should be given for the fitting of dentures. We are only referring to dentures, not routine dental care, which is currently reserved for a small group of veterans. Our aging needs are now.

The four public laws enacted by the Congress for needy veterans—Public Law 2, Public Law 86-211, Public Law 95-588, and Public Law 96-151—simply do not reach many thousands of our World War I veterans due to the restrictions contained in the laws or due to the mental and physical immobility of the veteran. Certainly you cannot sacrifice the care of war veterans to balance the budget.

We realize that there has been a reluctance to separate veterans according to wars. But the veterans of World War I are of another age, apart from all previous wars. Mostly volunteers or citizen soldiers, when the war was won we grabbed our service discharges and $60 clothing allowance and proudly called it a deal. There were no VA hospitals, just an informal medical inspection which would show no loss of arms or legs, and we were civilians. Little did we realize that many had been exposed to mustard gas which would, years later, cause lesions in the lungs, ending in TB.

Time and again this subcommittee has proven itself to be a friend of the veteran. But in view of the desire of the administration to hold down Federal spending, the stiff competition that exists for available Federal dollars and the difficulties that all standing committees are experiencing with Budget Committee recommendations, we realize that you are working in an atmosphere that makes for difficult decisions. That is to say, total resources made available through the appropriations and budgetary process cannot encompass all of the objectives that this subcommittee may wish to pursue. Yet, notwithstanding the realities to present economic conditions, we do believe that no Federal beneficiary has a greater or more moral claim for constant and fair health care than the aging veterans of World War I, for a generation which had experienced the horrors of the western front, horrors of such magnitude that "gone west" was a synonym for death for 20 years after World War I.

We are the elderly veterans of today. The majority of our hospital cases are terminal cases and should be considered such. We want now the same kind of services and care that is being planned for the veterans of World War II and other wars, not to be lessened in quality or quantity.

Our buddies need the outpatient care, prescriptions through the VA, regardless of service-connected disability, and anything else to ease the pains of growing old with dignity.

Sixty-eight years ago this Nation had a critical special need and nearly 4.5 million young Americans placed their services and their lives on the line to answer that need. Today, the aged remnants of that proud young army have a special need from the great Nation they defended.

Mr. Chairman, by allowing us this time, we know that you remember our veterans and their unique needs. For this, you have the profound gratitude of our organization. We are most appreciative of the special effort this subcommittee has always made in meeting the needs of America's wartime veterans. We sincerely hope that Congress will consider the health and medical problems of World War I veterans in a compassionate light.

Thank you for the opportunity to speak before this committee. Respectfully submitted, John Pavlik, national commander.

May I just add that we are in favor of H.R. 505 and feel it has some other things to take care of the World War I veteran.

Mr. EDGAR. Thank you very much for your testimony.

There is a lot of discussion today about the 10-year anniversary of the Vietnam war and the 40-year anniversary from World War II. It is an honor for us to have your testimony and your reference to 68 years in terms of World War I. It reminds us of the fact that that war was the war to end all wars——

Mr. PAVLIK. That's correct.

Mr. EDGAR [continuing]. And yet we still have conflicts in our Nation.

The focus of our legislation is on the aging veteran, and you are more qualified than almost all other veterans' organizations in helping us to understand the aging of our society. We appreciate your testimony today.

Mr. Penny, do you have any questions?

Mr. PENNY. No questions.

Mr. EDGAR. Thank you very much.

Mr. PAVLIK. Thank you.

Mr. EDGAR. Our next witness will be the American Legion, Mr. Paul Egan and Robert Lyngh. Welcome to our committee this morning. It is good to have you back, and it's nice not to have you last.

Mr. EGAN. That's right.

Bob Lyngh will summarize our statement.

Mr. EDGAR. Without objection, your full statement will be made a part of the record.

STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, AND ROBERT E. LYNGH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. LYNGH. Mr. Chairman, we have reviewed the language of H.R. 505 and we are in a position to say that the American Legion believes the provisions of the bill are appropriate and justified at this time and we are in support of them. We believe H.R. 505 should be favorably considered by the Congress.

We would like to use this opportunity to offer several comments about the specific provisions of the bill in context with the overall problems associated with the aging veteran population.

In the first place, the aging of the veteran population, primarily consisting of the World War II generation of American veterans, numbered some 10.6 million of the 16.5 million who served, now at an average age of 64.5 years, and closely followed by the 5.2 million surviving members of the Korean war generation, with an average age now standing at 55 years, are simply part of the general aging of the population, occasioned in the main by the steady extension of individual longevity among all Americans. The advances in medical and health sciences have allowed this to happen and it is, indeed, a marvelous thing.

But it must also be said that the extension of longevity, wonderful as it is, in itself creates new and additional problems that must be dealt with. Foremost among these, of course, is the provision of health care for our aging population. For those of us involved in veterans affairs, that means concern with health care for veterans.

It also bears stating that the Veterans' Administration has done a number of things, by and with the approval and support of the Congress, to provide health care for those older veterans who are entitled to care from the VA and who apply for such care.

Sometimes we of the Legion believe that in our general preoccupation with the needs of older veterans we fail to give due recognition to the fact that VA did become aware of the aging of World War II generation of veterans and did some years ago begin to make preparations in a number of ways to respond to the needs and demands that would flow from that fact. The reality that now, in 1985, much more needs to be done is because VA could only make progress to the extent of the resources available, and that perhaps no one really estimated with precise accuracy the size and complexity of the problems that would develop.

So we find ourselves in a situation in which much has been done and much more needs to be done. Some of what is needed is addressed in H.R. 505, and we of the Legion commend the chairman for having introduced it at this time. We perceive the bill as another congressional initiative to further facilitate the VA's efforts to deal with the multiplying health problems of the older element of the veteran population. In addition to the World War II and Korean generations of veterans, it is sobering to reflect that the Vietnam-era generation, some 8.2 million strong, is now at an average age in the mid thirties. From this it can be seen that the need for the VA to be able to deal with the diseases and health problems associated with age is a need that will not soon go away.

As an organization that counts in its membership of 2.6 million thousands of veterans from each of these generations, the American Legion is vitally interested in what VA will do and what Congress will authorize to help meet the Nation's commitment to the welfare of the men and women who have served in the Armed Forces and defended the national interest as that interest is defined by the elected Government.

Thank you, Mr. Chairman.

[The statement of Paul S. Egan and Robert E. Lyngh appears at p. 29.]

Mr. EDGAR. Thank you.

Are either of you planning to go to Bitburg, Germany, next week to commemorate the 40th anniversary of the end of World War II and have reconciliation?

Mr. LYNGH. I believe, Mr. Chairman, that you're trying to get us to say the American Legion is one organization that disapproves of the President's schedule on his trip to Europe.

Mr. EDGAR. That's correct. I want to commend you for that.

I have been a little bit frustrated that in the press and in the media, in reaction to the President's visit, it has been developed as though it were a Jewish issue—that is, the Jewish community's outrage at what took place. It seems to me that it is a Christian issue, and it's an issue of veterans and veterans' organizations, and I want to commend the American Legion for being out front in their frustration and opposition to the President's visit. I think there is still time for him to change his mind, to go someplace else, and to say it's a mistake. I hope he will take the opportunity to do that.

If he doesn't, I think it is incumbent upon the veterans' organizations to do something symbolic, perhaps on the same day, perhaps visiting some cemeteries here in this country and having a ceremony to focus on our feeling that it was inappropriate to visit that particular cemetery. So I want to commend you on that effort.

I hope that you might work with some of the other veterans' organizations to have a louder, clearer statement, perhaps a joint statement of the veterans' community, because I think to simply lay it out in the press as an issue relating to the holocaust or to the Jewish community is to misunderstand the whole concern of the larger community across the United States.

Let me ask you a question in relationship to the legislation before us.

Do I understand that you would recommend increasing the number of GRECC's beyond the 25 in our bill? I refer specifically to

page 6 of your testimony where you state your perception that GRECC's work best in conjunction with geriatric evaluation units and then recommend that every VA medical center should have one such unit.

Mr. LYNGH. Yes. Well, let me elaborate on that just a minute, Mr. Chairman.

In the first place, one of the conclusions that we have arrived at, based on our own work in the hospitals through our field service, is that it would be very helpful to the overall mission of the agency if every VA hospital now had a geriatric evaluation unit. We believe they have proved to be the most practical and effective way of dealing immediately with the problems of the older veteran when he presents himself for care.

Now, added to that, however, I want to say the point we were trying to make in our statement is that we're just a little bit frustrated by the fact that we supported Public Law 96-330 which increased the authorization for the GRECC's from 8 to 15. It took about 3 or 4 years to get 2 of them funded, and they are just really now getting underway, so we have gone from 8 to 10. There is no provision in the current budget and appropriations measures that are working their way through Congress, to our knowledge, to increase the number from 10 and beyond, and we don't see any immediate prospect of that. I think we have run into problems both with OMB and with the Congress—and we understand what the whole picture is.

But it seems to us a little bit of an exercise in futility to increase the authorization to 25 when you can't even get the 15 that you have already authorized.

Mr. EDGAR. Well, we indicated in our budget submission that we wanted to increase the number of GRECC's. We see this as a step-by-step process, first authorizing the number and then encouraging both the Budget and Appropriations Committees to move the number up.

You're not suggesting in your answer, I know, that you would not support that if, in fact, funds were made available——

Mr. LYNGH. We are very strongly in support of the GRECC's, sir.

Mr. EDGAR. Maybe we could have a GRECC next to each MX missile silo and just kind of add it as a condition.

Mr. EGAN. Just one further point about the geriatric evaluation units that has to be stated and understood clearly. That is, what we know about these units is that they are cost effective. Even though the average lengths of stay in those units are longer, the recidivism rate is less, which means significant savings. So in our headlong rush to save money this year and next year and the year after, we are not looking beyond the short-term at some significant savings that could be affected.

Mr. EDGAR. I appreciate that.

In the respite care area, I wonder if you have any comment on the issue which was raised earlier in testimony, as to whether or not we should change the language in our bill from "terminally ill" to "chronically ill" as the target population for respite care.

Mr. LYNGH. Well, yes. If that is necessary, Mr. Chairman—we were privileged to hear Dr. Mather's presentation, and perhaps we didn't carry our own thinking far enough when we were reviewing

the language of your bill. Let me say again what we said in our statement with reference to respite care.

We are not too sure of your utilization of language there, because you seem to use respite care in terms of dealing with the terminally ill patient. Our perception of that, and based on our knowledge of the hospice activities within the agency at the present time, is that it is generally referred to, as we gather in the lexicon of the medical world, as the hospice movement. We can see how you want to tie respite care in with that, but the way that we in our organization, in our concern with the VA Health Care Program, generally use the word "respite care" has been to refer to that procedure whereby the patient, the chronically ill patient being cared for in the home, can at intervals be admitted to an adult day care center, giving respite to the caretaker, which of course is very cost effective because it allows the veteran patient to be maintained outside the institutional setting.

I don't know whether any additional statutory authority is needed by VA to expand that program. But at a recent opportunity we had on the Senate side to discuss this with Senator Murkowski, the chairman, we wrote him a letter and we stipulated—and we sent this committee a copy of that letter—that all of these innovative modalities and technologies that are coming forth, both in VA and the private sector, in addition to all the other things they do, as being better for the veteran patient, are in almost all instances cost effective. It just makes sense to us that the VA should have all the statutory authority it needs to use all of these various modalities that are being developed, because this seems to be the way that medical science is going in dealing with the problems of the older person.

Mr. EDGAR. Let me just state publicly that it will be my intention to offer an amendment to my own legislation to shift to the chronically ill as opposed to terminally ill, because I think that——

Mr. LYNGH. Well, don't exclude the terminally ill, of course. The language of your bill explains it, a respite for the caretaker in that situation. I would add, if I may, that I have visited the hospice movement, the pilot program at West Los Angeles. They were doing that when I was out there a couple of years ago. I was out there as a member of that geriatric and gerontology advisory committee that was established by Public Law 96-330, and they were actually implementing respite care because the patient had free access in and out of the ward—in other words, he would go home with the family, and when it got to the point where he either had an acute episode or they needed some relief, he would come back in for a few days.

The thrust of that, however, in addition to respite, was to enable the veteran, as much as possible, to die in the bosom of his family, because it was the perception of those people who work in the hospice movement that it is better for the veteran patient and the family if he can die at home than to die in an institution. It is working beautifully out there.

I did say in my statement, if you will note, Mr. Chairman, that we're aware that other VAMC's are doing this, perhaps on a limited basis, but apparently again it's the forward thinking in medical science, the hospice movement, and we certainly do encourage it in

the VA. I think there is a strong place for it, considering the age of the overwhelming size of the veteran population that we have.

Mr. EDGAR. Very good.

Are there any other comments that you would like to make at this point?

Mr. EGAN. There is just one comment I would like to make.

Looking at the larger picture, it is pretty clear to us that the alternatives to institutional care, long-term institutional care, are cost effective and they are cheaper. We know, for example, that last year 41 percent of all the nursing home care in this country was paid for by Medicaid, not Medicare, which has to mean that a lot of those people that are having their nursing home care paid for by Medicaid have exhausted their Medicare benefits. Once they do that, all they have left to do is spend whatever resources they have, sell their property, cash in their insurance and so forth, so they can join the rolls of the poor in order to be eligible for a payment program which will take care of their nursing home care.

It seems appropriate to look at a void that appears to be unfulfilled at the present time, and that is that the private sector doesn't seem to have recognized the cost effectiveness of some of these alternatives to long-term institutional care and have failed to provide insurances covering these kinds of alternatives. It is pretty degrading, in our judgment, to look at the prospect of an individual, whether they be veteran or not, who becomes ill, had Medicare to take care of the initial illness, and then winds up in a long-term institutional setting for which they have no insurance, no way of addressing the cost, except to sell off everything they own and become poor as a result.

So I would suggest that in the interest of filling that void it might be of interest to this committee to take a look at whether or not the insurance industry is examining the cost effectiveness of the alternatives and whether or not they might be willing to address some of these needs.

Mr. EDGAR. I appreciate that comment.

We may have additional questions to submit for the record because of the number of members who are involved in other meetings. I know on our minority side they do have some questions for you. So we will submit those for the record.

Mr. EGAN. Thank you.

Mr. EDGAR. Our next witness will be from the Veterans of Foreign Wars, Mr. Jim Magill, assistant director, National Legislative Service.

Jim, we welcome you here and appreciate your testimony.

STATEMENT OF JAMES N. MAGILL, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. MAGILL. Thank you, Mr. Chairman, for the opportunity to present the views of the Veterans of Foreign Wars with respect to H.R. 505. I have a very brief statement, inasmuch as you have my full text.

I would first like to mention that we agree with Commander Pavlik that we must improve our ability to care for the aging vet-

eran now. I think one should remember that it was the World War I veterans who laid the groundwork for what we know today as the Veterans' Administration and they should be taken care of.

We fully support H.R. 505 and encourage its timely enactment. We believe your bill will enable the Veterans' Administration to be more effective in caring for the aging veteran, and we particularly applaud the more liberalizing features which would allow a veteran to remain with or near his family while in receipt of extended care.

H.R. 505's provision addressing respite care is, in our opinion, a much needed compassionate step for the veteran and his family. We hope it will be fully utilized.

The remaining provisions of your bill can only serve to ensure a more efficient and cost effective manner of providing care for our aging veteran.

This concludes my statement and I will be happy to respond to any questions.

[The statement of James Magill appears at p. 31.]

Mr. EDGAR. Without objection, the full text of your statement will be made a part of the record.

How come the Veterans of Foreign Wars have, to my ears, at least, been silent on the issue of the President's visit to Germany?

Mr. MAGILL. We have had many calls about that, sir. Not to dodge the question, but the legislative staff has not spoken out on this. We have our public affairs officer—again, not to evade the question—but he is more equipped at this point to respond to that.

Mr. EDGAR. Would you ask him to call me?

Mr. MAGILL. Yes, sir, I certainly will.

Mr. EDGAR. Would you take a message back to him?

Mr. MAGILL. I will do that, also.

Mr. EDGAR. Again, I just repeat what I said before. I was approached on the House floor by a Member of Congress who is active in the Jewish community. That Member of Congress said to me, as he knew I was active on the House Veterans' Affairs Committee, he could not understand why all of the national dialog seemed to be focused only on the reaction of the Jewish community. I did indicate to him that several other groups had made fairly strong statements. But I have to agree with him, that a large number of statements from the veterans' community have been fairly muffled and not very clear in terms of frustration and anger, apart from a few of the veterans' organizations that have taken a stand.

I think, in light of the Veterans of Foreign Wars strong support for the President over the last couple of elections, and in some of the efforts in supporting his Defense Program, the Budget Program and some of the other things, that it is important for an organization like yours, that has so much respect of the President, to also hear your views in times when you might, in fact, be critical of the President. So I would hope you would indicate to your public affairs person that at least one member of this committee and the chairman of this subcommittee would like to hear some message or word or sign that there is some concern.

Let me ask you the same question I asked of the American Legion in reference to the issue and debate between inclusion of

the term "chronically ill" with "terminally ill," so that it is clear that respite care can be provided to both.

Mr. MAGILL. We would support amending the bill to include the chronically ill, no question about it.

Mr. EDGAR. What do you think of the recommendation that the respite care provision be changed to include home-based care, home-based aspects?

Mr. MAGILL. As we have stated before, we feel that if a veteran can stay in his home and with his family, that is the best care at that time for that veteran. We would be in support of that.

Mr. EDGAR. Thank you very much. I have no further questions. There may be some questions submitted for the record.

Mr. MAGILL. Thank you, sir.

Mr. EDGAR. Our next witness will be from the Disabled American Veterans, Mr. David Gorman. David, we are very pleased to have you here this morning. The full text of your statement will be made a part of the record.

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Chairman. Good morning.

Initially, before I get into a summation of my remarks, I would like to again express the DAV's appreciation to you in your continuing efforts to aid the aging veterans and improve the medical care they receive from the Veterans' Administration.

Also, I would like to thank you, as chairman of this subcommittee, for the hearings conducted this past Tuesday and we extend our appreciation on the invitation of two of our national service officers to appear and testify. I am hopeful that their testimony gave the committee better insight as to the real problems that go on out there in the field on a day-in and day-out basis.

Mr. Chairman, I can sit here today and say that we are fully supportive of the measures and the provisions included in House Resolution 505. In that respect, I would like to direct my comments and summation to section 3 of that bill regarding domiciliary care.

The comments included in our written statement do recognize the fact that, as far as repeal of section 610(b)(1), there is, in fact, a liberalization and extension for domiciliary care to be provided on an equal basis to service-connected disabled veterans. We did, however, raise one concern only with reference to what we feel to be needed, possibly not in the statutory language, but certainly in the intent of this measure, and that is that a special emphasis should be placed upon the service-connected disabled veteran to enter into the domiciliary setting.

In reviewing the provisions of H.R. 505, I conducted an unscientific, obviously, minitelephone, survey of some of our national service officers who work in the field and are in close proximity to the existing 16 domiciliaries operated by the VA. Although they couldn't in some instances provide very firm figures because of a lack of response from the domiciliaries, it was indicated that the percentage of or the ratio of service-connected veterans to non-service-connected veterans in a domiciliary setting is extremely dispro-

portionate. I think the best instance we saw was that in one domiciliary they had a daily census of about 400, service-connected veterans, comprised about 25 percent of that population. That was the best example we were able to get. In most instances, it was down to around 12 and 13 percent service-connected veterans.

We think the domiciliary as a rehabilitative avenue of medical care is a valuable asset in the Medical Program administered by the VA. The sole purpose of our concerns about section 3 of H.R. 505 is simply to place within the Veterans' Administration the emphasis to service-connected veterans to participate in that program. We certainly have no objection to the change in language.

That would conclude my remarks, Mr. Chairman, except to again say we do support this bill and again appreciate the opportunity to appear.

[The statement of David W. Gorman appears at p. 32.]

Mr. EDGAR. Thank you very much.

Let me ask you as well your position on the President's visit to the cemetery in Germany and whether or not your veterans' organization has taken a stand, a position, developed a policy.

Mr. GORMAN. The DAV, Mr. Chairman, as you know, is primarily geared from a policy standpoint and position standpoint to improving the benefits for service-connected, disabled veterans, and we more or less stick by that policy and position stance.

We have not taken a position officially. That is not to say, as Mr. Magill stated, that we haven't received telephone calls. We have received letters of inquiry. I think all those are being responded to based on our personal feelings as individuals, echoed by yourself.

Mr. EDGAR. I understand the original purpose of your organization in that respect. I do think there are times when, not only as organizations but as individuals, it is time to stand up and speak out. My guess is that if someone very ultra-liberal would come out and attack the veterans' community in general, that your organization would have a statement, even though your primary focus is legislative. In fact, I have heard that in the past on just a couple of occasions. So it seems to me that if there is concern generally voiced by individuals within your organization in reference to this ceremony that is to take place, it might make sense to evaluate whether or not in the best interests of your disabled veterans there isn't a statement to be made in a kind and generous way to the President about his visit.

Let me assure you that in the report language of this legislation, we will make sure that on the focus of domiciliary care our provision is to equalize the opportunity for service-connected veterans, not to diminish it, as you suggest in your testimony. We will make that as clear as we can.

Mr. GORMAN. We appreciate that.

Mr. EDGAR. I would like to yield to counsel on the minority side for questions.

Mr. WILSON. Mr. Gorman, do you recall the income factor for being admitted to a domiciliary?

Mr. GORMAN. I believe right now, in current regulatory form, it is not to exceed $475 monthly income.

Mr. WILSON. What is the amount of compensation that about a 40- or 50-percent disabled veteran receives who is service connected?

Mr. GORMAN. Mr. Wilson, I don't think I can respond to that.

Mr. WILSON. If it exceeded that amount, would that person be precluded from going into a domiciliary?

Mr. GORMAN. I can offer you an example as an illustration in response to your question.

I contacted our national service office in Phoenix, AZ, I believe on Monday of this week, and posed that question to him. Strangely enough, from our national service officers, they don't seem to receive inquiries on a very frequent basis from veterans as to the availability of domiciliary care. It was this one exception, though, in Phoenix where a veteran who was 70-percent service-connection disabled applied for admittance to a domiciliary. He was denied admittance based on his compensation exceeding the $475 monthly figure.

Mr. WILSON. Thank you, Mr. Chairman.

Mr. EDGAR. I would just like to congratulate you on the two service officers who did testify on Tuesday, and also commend them for their answers under some fairly strong and at times hostile questioning by my colleague from Pennsylvania, Mr. Gekas. I appreciated their frank responses and their participation in that hearing.

Mr. GORMAN. Thank you very much. We appreciated the opportunity.

Mr. EDGAR. Thank you. I have no further questions.

Mr. GORMAN. Thank you, Mr. Chairman.

Mr. EDGAR. Our final witness will be the Paralyzed Veterans of America, Mr. Frank DeGeorge, associate legislative director.

STATEMENT OF FRANK R. DeGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. DEGEORGE. Good morning, Mr. Chairman.

Mr. EDGAR. Good morning.

Mr. DEGEORGE. PVA is most appreciative of the efforts of the subcommittee chairman to introduce this legislation and to conduct this important hearing today. The PVA's concerns relate directly to the needs of catastrophically disabled spinal cord injured veterans, regardless of their age, their family members, and those significant care givers who provide the necessary support and assistance to the spinal cord injured veterans.

Very succinctly, PVA is in support of H.R. 505 with the provisions and under advisement that the chairman consider that respite care programs be provided to not only older veterans but younger catastrophically disabled veterans as well, and to include both service- and non-service-connected veterans.

Regarding section 6 of H.R. 505, regarding the GRECC programs, PVA is also supportive of your efforts to authorize an increase from 15 to 25 GRECCs. Again, we would suggest the GRECC program include the study of the needs of aging spinal cord injured veterans, which is very much of a concern of PVA.

Rather than to elaborate any further or read any further from my statement, on behalf of PVA I would at this time conclude my

statement, again thanking you for this opportunity and that of your staff for their assistance in this matter and in having this hearing.

[The statement of Frank DeGeorge appears at p. 33.]

Mr. EDGAR. Thank you for your testimony.

I was just speculating, that since you agreed so much with the legislation, why don't we just move to the markup. I think I have a majority here of the votes. Well, we'll do that a little later.

What is your opinion of the Bitburg visit? Have you taken a position as a veterans organization?

Mr. DEGEORGE. I believe that is under evaluation by the organization at this point, but I would also state, as did the DAV representative, Mr. Gorman, that PVA's main concerns have always been and are medical care for our membership. But as you have shown a great interest, I will carry your message back to our organization of your concerns. At this time I don't think we have established a position, though.

Mr. EDGAR. Please tell them that one member of this subcommittee is very interested and would like to hear from them, even if the answer is they choose not to take a position. I think you ought to evaluate that possibility simply so that the Nation as a whole is clear as to the feelings generally of the veterans community on that issue. It has taken such a high profile nationally that not to speak and to be clear would be a mistake. I think often we are very silent on issues that are often controversial and it is important for us not to be silent here.

Mr. DEGEORGE. I will carry your message with expedience, sir.

Mr. EDGAR. Thank you.

Mr. DeGeorge, you express support on behalf of the PVA for the respite care program and you described a home-based type of program. What experience has your organization had with this type of respite care program and would you oppose the kind of respite care program proposed in H.R. 505?

Mr. DEGEORGE. First of all, PVA has had experience with hospital-based home care programs. There are 19 spinal cord injury centers, as you know, nationwide. Within those 19 centers, or beyond those 19 centers, there are 49 VA hospitals that are involved in hospital-based home health care. The 19 spinal cord centers are also involved in that program, and I believe in our annual testimony we stated that within the spinal cord injury services that over 2,000 home visits were provided to both service- and non-service-connected veterans in the home, using the hospital-based home health care program.

Beyond the hospital-based home health care program, if I may add, as I have heard here this morning, there seems to be a need to express that there are various kinds of respite care programs by definition that go beyond what is stated in the bill. I am aware of individuals who were not involved in hospital-based home health care programs but received respite care in their home. I recall as far back as 1969 some VA hospitals providing this kind of care to veterans in their homes, to allow them to stay in the home while providing some assistance to family members or spouses. It was very effective in maintaining the veteran in the community, where-

as he or she did not have to go back into the hospital or institution for care.

Regarding your definition in the bill as only applying to institutions, nursing homes and domiciliaries, I believe that you could go beyond in defining what respite care means, as I have just stated, in reference to hospital-based and respite home care programs.

Mr. EDGAR. Thank you very much. We may have some questions to submit for the record. We appreciate your coming forward.

Before we end the hearing, let me be clear with everyone as to why I raised the question about the President's trip. Almost every veterans organization stood up and condemned an action by the Vietnam Veterans of America when a wreath was laid at a ceremony in Hanoi. There was frustration, there was anger, and I personally felt that that was wrong at that time, even though I understood the circumstances around which it took place. I just find it interesting that there is silence at this point but anger several years ago. So that is why I am pushing a little bit to see if the organizations can take a second look at a public statement because I think it is important for the general public to see that both of those things may not be appropriate for a nation that is trying to honor and respect the views of its veteran population and its community.

We have done a lot in the last several years to honor the veteran of the Vietnam era. We have done a lot to try to improve the quality of veterans care and services. There is some criticism out in the general public as to some of the hospital and health care that is provided to veterans across the country, but we were attempting to improve the image there. I think it is important, if we honor our veterans in a very positive way, that we do it with some tact and tastefulness. I would hope that the veterans organizations, in the same fury that they had with the Vietnam Veterans of America action, would also take a look at this one.

I thank everyone for participating in the hearing today. I want it to be noted that Bob Edgar finished a hearing in one hour and thirty minutes, which is a record. We also appreciate the fact that the Veterans' Administration stayed to listen. We always appreciate the fact that all of you have taken the time to come.

This hearing stands adjourned.

[Whereupon, at 11 a.m., the subcommittee was adjourned.]

APPENDIX

STATEMENT OF JOHN H. MATHER, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR, FOR GERIATRICS AND EXTENDED CARE, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS ADMINISTRATION

Mr. Chairman and members of the subcommittee, I am pleased to have the opportunity to present the views of theVeterans Administration on H.R. 505.

With the deletion of section 6 of the bill which would authorize expansion of the GRECC program, and revision of the bill's respite care provision, we would favor the enactment of H.R. 505. A bill revised along these lines would greatly assist the VA in managing the care of aging, chronically ill patients already in VA medical programs. VA could implement such a revised bill without incurring significant additional costs.

RESPITE CARE PROGRAM

Section 2 of H.R. 505 would permit the VA to furnish "respite care" to veterans currently eligible for VA hospital or nursing home care. The bill defines respite care to mean hospital or nursing home care provided in a VA facility on an intermittent or temporary basis to a veteran who has been diagnosed as suffering from a terminal illness and who is receiving care in the individual's home or in a hospice program under contract with the VA. This provision is troublesome in limiting respite care to the terminally ill. We believe that the authority to furnish respite care to chronically ill vetrans could prove a useful means for avoiding or delaying prolonged, costly institutionalization. Limiting the scope of this provision to veterans whose illnesses are terminal, however, would seem to be unwarranted from a medical and social perspective. The focus of respite care should be to ease the burden on those at home who care for chronically ill patients. In that connection, it is not clear how transferring a patient for brief periods from a hospice setting to a VA facility, as contemplated in the bill, fosters that purpose.

We believe the development of new VA health care programs is best approached on an experimental basis. Thus, although we do not favor section 2 of this bill, as introduced, we recommend that Congress enact legislation to authorize VA to provide respite care on a three-year pilot test basis for those chronically ill veterans who have the highest claim to VA services—service-connected disabled veterans—and that this care be provided at a limited number of facilities in conjunction with hospital-based home care (HBHC) programs. This pilot test, using existing funds, would include an evaluation to determine whether or not the program should be continued. We recently submitted a legislative proposal to the Committee to provide such respite care authority and we urge that you adopt our proposal.

If our proposal were enacted VA implementation is not anticipated to involve significant additional expenditures. We would furnish respite care in existing operating beds with placements based on local needs assessments and resource availability.

DOMICILIARY CARE ELIGIBILITY

Section 3 of the bill would establish a single standard of eligibility for domiciliary care. As such, it would eliminate the substance of section 610(b)(1), a provision which sets a more demanding standard of eligibility for the service-connected veteran than for the nonservice-connected. We favor this provision. Its enactment would not result in additional costs.

OUTPATIENT CARE FOLLOWING NURSING HOME OR DOMICILIARY CARE

Section 4 of the bill would authorize VA to provide limited outpatient treatment to veterans discharged from VA nursing homes and domiciliaries. Under existing

authority, the VA may furnish a veteran with a nonservice-connected disability outpatient care to complete treatment begun during VA hospitalization. Since patients in Va nursing home care units and domiciliaries often have no direct eligibility for follow-up outpatient care, many of these patients remain institutionalized longer than necessary—often for prolonged periods—to complete their treatment. We favor the enactment of this provision, because it would permit a more rational system for appropriately meeting our patient's medical needs. Not only would this provision help veterans make the transition from institutional to community placement, it would also result in better utilization of facilities. If enacted, this provision would result in no additional costs to the VA because these medical services would be provided within planned resources.

COMMUNITY NURSING HOME CARE ELIGIBILITY

Section 5 of the bill proposes a series of amendments to section 620 of title 38, under which VA administers the community nursing home care program. We favor the enactment of section 5. In general, it would improve our capability to provide patients with the most appropriate treatment.

For example, under existing law, the VA's authority to place veterans requiring nursing home care for nonservice-connected conditions in community nursing homes is limited. Contract nursing home placements for such veterans may only be made on behalf of those individuals who require such care following VA hospitalization. These limitations preclude the VA from transferring to community nursing homes, patients who have been receiving home health services as well as patients in Va domiciliaries and nursing home units. Under current practices, when the condition of a patient receiving home health services under the VA's hospital-based home care program is found to require nursing home care, the patient is typically readmitted to a VA hospital and then transferred to a community nursing home. Enactment of section 5 would permit the transfer of hospital-based home care patients directly to nursing home care consistent with the standard medical practice. Inasmuch as current medical and administrative practices provide a means of placing recipients of home health services in community nursing homes when the need arises, enactment of this proposal would not entail additional costs. We favor enactment of this provision as well as the proposed amendment authorizing VA to transfer patients from VA nursing home care units and domiciliaries to community nursing homes. Enactment of the amendment authorizing this transfer authority would enable VA to care for more patients at an appropriate level of care in VA nursing home units and domiciliaries because of the turnover from these community nursing home placements. We anticipate that enactment of this amendment would not result in additional costs. Care would be furnished within planned resources.

Section 5 would also provide helpful clarification of the duration of nursing home care afforded service-connected veterans. Provisions of law now permit unlimited community nursing home care to veterans for any condition following VA hospitalization, if that hospitalization is primarily for a service-connected disability. Veterans who are hospitalized for a nonservice-connected disability but who require care for their service-connected disabilities are restricted to six months' care. Likewise, veterans who are admitted to a contract nursing home directly from the community for a service-connected condition are limited to six months' care. This poses a somewhat irrational distinction in access to care for service-connected veterans—providing unlimited care only to those who happen to have been hospitalized for their service-connected conditions prior to nursing home placement, and treating all others who require nursing home care for their service-connected conditions as if they were nonservice-connected. We believe it is the intent of Congress to provide unlimited nursing home care to veterans for their service-connected disabilities, and that the law should be amended to reflect that intention. The number of veterans who might be affected by such a statutory change cannot be accurately estimated; however, it is felt to be limited and is considered to be insignificant in relation to the overall program and its costs. We anticipate no significant costs resulting from enactment of this provision, because the program is budgeted on the basis of an annual census by average daily costs.

We also favor the proposed amendment of section 620(e) which seeks to resolve an issue regarding VA per diem payments under 38 U.S.C. § 641 to States providing nursing home care in State homes. Section 641 contains a single per diem rate for payment of nursing home care furnished eligible veterans in State Veterans Homes. Some States with State veterans Homes recognized by the VA for nursing home care have obtained Medicare certification as a skilled nursing facility or Medicaid certification as a skilled or intermediate care facility, or both. A question could be

raised whether payments for care in both types of facilities should be at the rate for nursing home care since the general definition in 38 U.S.C. 101(28) for nursing home care refers to patients who require skilled nursing care. The two terms, skilled nursing facility and skilled nursing care, are not synonomous. The VA has paid the existing nursing home rate, rather than the clearly inappropriate domiciliary care rate, for care provided in State home nursing homes which meet VA standards of care regardless of the designation of that facility as skilled or intermediate. We believe a technical amendment such as is proposed in section 5 would resolve this matter; thus, we favor this proposal. Enactment of this provision would not result in additional costs to VA.

EXPANSION OF GRECC PROGRAM

Section 6 of the bill would authorize an expansion of the Geriatric Research, Education, and Clinical Centers (GRECC) program by authorizing the VA to establish and operate up to twenty-five centers. The VA currently operates ten GRECCs. We foresee no need at this time for additional legislative authority for this program, and do not favor enactment of section 6. Implementation of such a provision would entail five-year costs in excess of $21 million.

That concludes my statement, Mr. Chairman. I will be please to answer any questions you or members of the Subcommittee may have.

STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, AND ROBERT E. LYNGH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and members of the subcommittee, the American Legion appreciates the opportunity to appear at this time to offer comment on H.R. 505, the "Older Veterans' Health Care Amendments of 1985."

Mr. Chairman, we have reviewed the language of the bill, and we are in a position to say that The American Legion believes the provisions of the bill are appropriate and justified at this time, and we are in support of them. We believe H.R. 505 should be favorably considered by the Congress. We would like, however, to use this opportunity to offer several comments about the specific provisions of H.R. 505 in context with the overall problems associated with the aging veteran population.

In the first place, the aging of the veteran population, primarily consisting of the World War II generation of American veterans, numbering some 10.6 million of the 10.6 million of the 16.5 million who served, now at an average age of 64.5 years, and closely followed by the 5.2 million surviving members of the Korean War generation, with an average age now standing at 55 years, are simply part of the general aging of the population, occasioned in the main by the steady extension of individual longevity among all Americans. The advances in medical and health sciences have allowed this to happen and it is indeed a marvelous thing. But it must also be said that the extension of longevity, wonderful as it is, in itself creates new and additional problems (if that is the proper word) that must be dealt with. Foremost among these, of course, is the provision of health care for our aging population. And for those of us involved in veterans affairs that means concern with health care for veterans.

It also bears stating that the Veterans Administration has done a number of things, by and with the approval and support of the Congress to provide health care for those older veterans who are entitled to care from VA, and who apply for such care.

Sometimes, we of the Legion believe that in our general preoccupation with the needs of older veterans, we fail to give due recognition to the fact that VA did become aware of the aging of the WW II generation of veterans, and did some years ago begin to make preparation in a number of ways to respond to the needs and demands that would flow from that fact. The reality that now, in 1985, much more needs to be done is because VA could only make progress to the extent of the resources available, and that perhaps no one really estimated with precise accuracy the size and complexity of the problems that would develop.

So we find ourselves in a situation in which much has been done, and much more needs to be done. Some of what is needed is addressed in H.R. 505, and we of the Legion commend the Chairman for having introduced it at this time.

Section 2 of the Act would amend sections 601 and 610 of title 38, United States Code, to include "respite" care among the types of care to be provided by the Department of Medicine and Surgery.

"Respite care," in the Act is defined as: hospital care or nursing home care provided in a Veterans Administration facility on an intermittant or temporary basis to a veteran who has been diagnosed as suffering from a terminal illness and who is receiving care in the individual's home or in a hospice program which has entered into a cooperative agreement with the Veterans Administration to provide appropriate care for the veteran.

This section of the Act would place in statute something the VA has in fact begun to do on a limited basis. The hospice movement is now a well-defined element of health care delivery in this country as a method of providing appropriate care for the terminally ill, and where possible to assist and guide family members to help the patient through the terminal phase of the illness. The hospice movement apparently began in England, where it is now widely used, and it is becoming more and more found in communities throughout our own country. It is generally accepted in the medical professions as an approved element of health care delivery.

Presently the VA has a prototype unit of hospice care functioning at one of its Medical Centers (we believe this is at the VAMC West Los Angeles). We are aware there are other VAMCs that are also developing hospice units, we believe in their Medical Services, on an experimental basis. H.R. 505 would regularize what is being done, and encourage VA to expand the program.

The reports of our Field Service visitations indicate the program is well received where it is being done, not only by the VAMC staffs, but also by family members. Our perception is that it is also well accepted by the patients concerned in that it provides comfort and support during the terminal phase of an illness. The American Legion is strongly in favor of it and we believe it is now appropriate to recognize its value in statute.

Inasmuch as the program is generally known as the "hospice movement," we wonder whether it would be preferable to so identify it in the Act, so that it will become part of the lexicon of the VA's health care program under that title.

Section 3 of the Act would modify subsection (b) of section 610 of title 38, USC, to eliminate the restrictive language of subparagraph (1) of the section, and make domiciliary care available to those veterans who need it both from the standpoint of physical and economic condition.

The American Legion agrees with the language of this section.

Section 4 of the Act would amend section 612(f)(1)(B) of title 38, to add domiciliary and nursing home care to hospital care as qualifiers for medical services. The American Legion believes this is an appropriate amendment.

Section 5 of the Act would amend section 620 by modifying the language of subsections (a), (d), and (e) of the section. The American Legion has no problem with these adjustments.

Section 6 of the Act would amend section 4101(f)(A) of title 38, USC, by striking out "fifteen" and inserting in lieu thereof "25".

This amendment has to do with the GRECC program within the Department of Medicine and Surgery. The history of this program, as we recall it is that the establishment of the first GRECCs was an initiative undertaken by VA, as one of the elements of its overall effort to deal with the oncoming problems of the aging veteran population. The GRECCs are Geriatric, Research, Education and Clinical Centers, established in VAMCs. In the initial phase of the program, 8 GRECCs were established, and they have been in operation for several years when they were first recognized by Congress in the language of Public Law 96-330, which authorized the establishment of a total of fifteen GRECCs. The authorization was effective for Fiscal Year 1981.

The original plan of the VA, as we recall it, was to establish two GRECCs, under the new authorization, for each succeeding Fiscal Year beginning with FY 1981. That plan was never realized. As it turned out, VA DM&S managed to initiate action for two additional GRECCs, under this authorization, for the current Fiscal Year. We are not aware that any additional GRECCs are planned for Fiscal Year 1986.

This situation with reference to the GRECCs raises the question of whether there is any practical reason to modify the authorization further, to authorize a total of 25 GRECCs, when the current authorization for 15 has existed for four years, with 10 GRECCs functioning and no more planned?

We will tell the Subcommittee that our Field Representatives survey the GRECCs in each of the VAMCs where they find one during their regular visitation schedule. The reports of the Field Representatives confirm that the GRECCs are indeed a good and useful element of the planning and care for older veterans. Some of them are doing exciting work in research on the diseases associated with age. They are providing excellent education for student physicians and other health care profes-

sionals in geriatric medicine. Our perception is that they work best when they can be associated with a Geriatric Evaluation Unit (GEU). It is one of The Ameican Legion's recommendations that every VAMC should establish a GEU as soon as possible. There are no VAMCs that are not dealing with an increasing increment of aging veterans as both outpatients and inpatients. The GEU is the most efficient and effective way to establish a treatment plan for these patients.

Mr. Chairman, and Members of the Subcommittee, we perceive H.R. 505 as another Congressional initiative to further facilitate the VA's efforts to deal with the multiplying health problems of the older element of the veteran population. In addition to the WW II and Korean generations of veterans, it is sobering to reflect that the Vietnam Era generation, some 8.2 million strong is now at an average age in the mid-thirties. From this it can be seen that the need for VA to be able to deal with the diseases and health problems associated with age, is a need that will not soon go away. As an organization that counts in its membership of 2.6 million, thousands of veterans from each of these generations, The American Legion is vitally interested in what VA will do, and what Congress will authorize, to help meet the nation's commitment to the welfare of the men and women who have served in the Armed Forces, and defended the national interest as that interest is defined by the elected Government.

We commend the Subcommittee for the foresight represented in H.R. 505.

STATEMENT OF JAMES N. MAGILL, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and members of the subcommittee, thank you for the privilege of appearing before this distinguished Subcommittee to present the views of the Veterans of Foreign Wars of the United States with respect to H.R. 505, a bill introduced by you, Chairman Edgar, entitled the "Older Veterans' Health Care Amendments of 1985." We appreciate your introducing this legislation and for holding this hearing, demonstrating your continuing concern for the wellbeing of our nation's aging veteran population.

As you know, the VA health care system is now being faced with a great challenge—the ability to adequately and properly care for a very rapidly aging veteran population. Although the average age of the entire American population is escalating, the pace is much more rapid among veterans. In just as few as fifteen years, two-thirds of all American males over the age of 65 will be veterans and 115,000 of these veterans, it is estimated, will use the VA's extended care program daily.

Mr. Chairman, the VFW fully supports the provisions of H.R. 505. The enactment of your bill would certainly enable the VA to be more effective in caring for the aging veteran while at the same time availing that veteran and his family to more options in receiving such care. In particular, we applaud the many liberalizing features that would allow a veteran to remain with or near his family while in receipt of extended care.

One provision of H.R. 505 would provide respite care to veterans suffering from terminal illnesses. Respite care, a relatively new concept in this country, combines the benefits of home care and that sometimes necessary care which can only be provided by a medical facility. We view this provision as a compassionate step for both the veteran and his family. While the VA has experimented with the feasibility of respite care, current law does not clearly indicate when it may be authorized. Your bill effectively resolves this discrepancy.

We also view as a welcome improvement the provision allowing certain veterans to be eligible for follow-up medical care from the VA on an outpatient basis. This provision would allow for more veterans to be discharged from VA nursing homes and domiciliaries thus providing the VA with the ability to treat more veterans in these facilities while not having to add more beds to the VA system.

Mr. Chairman, we believe section 5 of your bill is an improvement which will not only be beneficial to veterans but will ultimately prove to be a cost savings to the VA. By allowing a veteran to be transferred at VA expense directly from a VA nursing home or domiciliary to a community facility without first having to be discharged from a VA hospital will eliminate many unnecessary and costly hospital admissions. This section would also improve current law by permitting veterans who require nursing home care for treatment of a service connected disability to be provided such care without it having to be reauthorized every six months; and authorize the VA to make per diem payments to states providing intermediate nursing care to veterans being cared for in state nursing homes.

Mr. Chairman, H.R. 505 also would expand the authorization level of the Geriatric Research, Education, and Clinical Center (GRECC) Program from 15 to 25. As we

have stated in the past, the VFW fully supports the GRECC Program and have continually called for its being implemented to its full authorization level. We are, though, disappointed in that only ten GRECCs are currently operational and even more disappointed that FY '86 Budget request provides no additional funding for this valuable program. While we support the increase in the authorization level to 25; we believe thirty GRECCs, one in each medical district, should be the targeted goal.

Finally, your bill would rectify an inequity in the admissions procedure to VA domiciliaries by affording veterans with service connected disabilities the same priority as is enjoyed in other parts of the VA health care system.

Mr. Chairman, this concludes my statement. Again the VFW appreciates your introducing this beneficial legislation and we support its early enactment. I will be happy to respond to any questions you may have.

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, FOR MEDICAL AFFAIRS

Mr. Chairman and Members of the Subcommittee, on behalf of the one million members of the Disabled American Veterans, I want to take this opportunity to thank you and the members of the Subcommittee for allowing us this opportunity to present our views regarding H.R. 505, the "Older Veterans Health Care Amendments of 1985."

Mr. Chairman, before proceeding with my testimony, let me begin by extending to you the DAV's genuine and sincere appreciation for the interest and concern displayed by yourself and this Subcommittee toward this nation's "graying" veterans' population. Your interest in this area is perhaps best exemplified by the hearing conducted on June 13, 1984, by this Subcommittee, in which the VA's research efforts concerning the aging veteran was thoroughly discussed and explored.

Mr. Chairman, Section 2 of the bill proposes, through appropriate amendment to Section 601, Title 38, USC, to define the term "respite care" and prescribe to what extent it may be provided by the VA to an eligible veteran.

Mr. Chairman, it is our understanding that respite care would be targeted at those veterans who have been diagnosed as suffering from a terminal illness and are residing and receiving care in their homes.

Generally stated, this type of program will provide veterans with short term, intermittent or temporary stays at VA facilities in order to provide the principial care givers—usually family members—with a "break" from providing constant care and monitoring of the veteran.

This type of alternative approach will not only provide incentives for principial care givers to continue to provide necessary care in the home, but will also contribute to a reduced incidence of hospital or nursing home admissions for long-term care.

For these reasons, Mr. Chairman, we favor enactment of this provision.

Section 3 of the bill, by appropriate amendment to Section 601(b), Title 38, USC, proposes to redefine the eligibility criteria permitting veterans to be furnished VA domiciliary care.

Mr. Chairman, the VA Domiciliary Program may be described as a minimal medical care model capable of providing a full spectrum of medical care to eligible veterans constituting but one segment in a health continuum, without which veterans could be forced into higher levels of care or do without required care.

A domiciliary provides to eligible, ambulatory veterans continuing medical care in a therapeutic institutional environment, including rehabilitative assistance and other therapeutic measures. Although a domiciliary provides less intensive care than a hospital or nursing home care unit as measured by the required intervention of a nurse and/or physician, it provides a higher level of care than found in residential care settings.

The focus of care is directed at preparing veterans to function at their highest level of independence. Some patients may require continuing care for an indefinite period, but the ultimate goal is the return of the veteran to independent functioning in the community.

Mr. Chairman, while we do not have any major objection to the intent of this provision, we are, nevertheless, concerned with the proposed repeal of current statutory language which will, in our view, diminish the emphasis that should be placed on service-connected veterans for participation in this VA medical care program.

Therefore, if favorably reported by the Subcommittee, we urge that language be included that would attach a priority or place the emphasis, for domiciliary care to the service-connected disabled veteran.

Section 4 of the bill would amend Section 612(f)(1)(B), Title 38, USC, to permit the VA to furnish medical services, on an outpatient or ambulatory basis, when a veteran has been furnished not only hospital care, but also nursing home or domiciliary care, when such care is necessary to complete treatment incident to such care.

Mr. Chairman, the DAV has no objection to enactment of this provision.

Section 5 of the bill proposes to make appropriate amendment to Section 620(a), Title 38, USC, to permit the Administrator to transfer patients from VA nursing homes and domiciliaries to private or public nursing homes.

Additionally, clarifying language would be included delineating that when nursing home care is required for the treatment of a veteran's service-connected disability, the restriction of providing nursing home care for not more than six months in the aggregate is not applicable.

Finally, this section proposes to authorize the Administrator to effectuate direct admissions to any public or private institution which furnishes nursing home care for a veteran who has been discharged from a hospital under the direct jurisdiction of the VA and who is receiving home health services under a VA hospital based home care program.

Mr. Chairman, the DAV has no objection to enactment of ths section of the bill.

Section 6 of the bill would, by appropriate amendment to Section 4101(f)(1)(A), Title 38, USC, expand the number of Geriatric Research, Education and Clinical Centers (GRECC) from 15 to 25.

Mr. Chairman, the (GRECC) program represents an important aspect of the VA's response to the health care needs of aging veterans. It serves to attract and develop superior staff in the field of gerontology and geriatrics and to advance and integrate research and educational achievements into the VA health care system. In addition to providing a balanced program of research, education and clinical care in the field of geriatrics, each GRECC is charged with providing a specialized research component with a particular focus—such as behavioral disorders or rehabilitation.

Studies by VA investigators in GRECCs and other geriatric research programs range from clinical investigations and the development of innovative health care delivery systems to high priority basic science studies designed to increase the body of knowledge concerning the basic biological process of aging. This, in turn, will help form the foundation for future research and treatment aimed at delaying the age related degenerative processes that make the elderly so vulnerable to physical, functional and mental disorders.

Additional, the VA is exploring a number of approaches to deal with the aging veteran situation, one of which is to reduce the demand for health care services by reducing the need for them.

Mr. Chairman, in our view, the GRECCs constitute a vital activity within the Veterans Administration and, for this reason, we favor enactment of this provision of the bill.

Mr. Chairman, this completes my statement. Again, the DAV deeply appreciates having been given the opportunity to present our views on this most important subject.

STATEMENT OF FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR

Mr. Chairman and Members of the Subcommittee, it is a privilege for Paralyzed Veterans of America to appear today and present the views and concerns of its members regarding H.R. 505, the "Older Veterans' Health Care Amendments of 1985." I am Frank R. DeGeorge, Associate Legislative Director of Paralyzed Veterans of America.

We are appreciative of the efforts of the Subcommittee's Chairman to introduce this legislation and to conduct this important hearing today. The PVA's concerns relate directly to the needs of catastrophically disabled spinal cord injured (SCI) veterans, regardless of their age, their family members and those significant caregivers who provide the necessary support and assistance to the SCI veterans.

Realizing full well the ever increasing costs associated with hospital health-care, especially for the chronically ill or long-term disabled veteran, alternatives to institutional care need to be developed. PVA, based upon its own knowledge of the subject and by the research obtained, delving into the role of the "significant other," as it protends for the aging SCI veteran, strongly supports the implementation of a VA sponsored respite care program. Respite care is a concept that provides short term relief from the responsibilities of caring for a chronically ill or disabled family member, while helping to maintain family equilibrium. Respite care programs serve elderly or impaired individuals who want to remain at home, and care givers who want to care for the relative or spouse at home.

PVA supports a VA respite care program that offers assistance not only to the aging veteran, but also to the catastrophically disabled veteran, regardless of age. We believe respite care programs that serve the chronically disabled can be cost effective while serving the needs of the provider, the consumer, and the care giver.

In PVA's testimony delivered on June 13, 1984, before the House Subcommittee on Hospitals and Health Care, Dr. George Hohmann, Ph.D., expressed concern for the aging SCI veterans who seek assistance in the home or dormitory home to alleviate the need for admittance to VA medical centers and nursing homes. A respite care program is very much needed for the SCI veteran attempting to return to and maintain personal residency in the home environment.

To maintain the SCI veteran in the home dictates providing support services to both the veteran and his family care givers. Respite care programs are ideal in that they are designed to relieve the emotional and physical stresses of both the SCI veteran and his spouse or "significant other" who provide the needed care. The program we advocate would provide carefully trained people to go into the home, to allow the "significant other" the opportunity to take care of business, the shopping, errands, or simply time for themselves, relieving them temporarily from the burden of providing long term care. Respite care is also necessary when the "significant other," be it a spouse or family member, suffers a personal injury or illness.

A respite care program will offer health care in the home environment in lieu of an institutional setting. Realizing the ever-increasing cost associated with care provided in a hospital or in a nursing home, respite care can prove to be very cost effective. For example, the cost of providing three hours of care daily, by a licensed practitioner in the home, is considerably less than the cost of three hours of any service provided by a hospital or nursing home, if such services were available.

Implementation of respite care programs are growing nationwide. They are supported in various ways through federal and state funding, and by some private insurance. For example, in the State of New York respite care programs are being conducted for the elderly through senior citizen programs, and, the State of Washington is presently conducting five different respite care pilot projects with resultant reports forthcoming.

The requirement for the VA Administrator to report to Congress on respite care is a needed and overdue action. Hopefully, the report of the Administrator will address the need for respite care to help alleviate the psychological burdens placed on family members. Often the day-to-day care provided by a family member is overlooked even though it is essential in precluding a veteran's institutionalization. The respite care program in combination with and/or extension of VA Hospital Based Home Care, outpatient and other VA programs can only serve the government in a cost-effective manner by reducing the need of institutional care for veterans needing long-term care.

As we stated in similar testimony before your committee on June 13, 1984, the Veterans Administration is in the unique position to incorporate into its program on aging an inclusive investigative research profile on the psychological, medical, sociological, and economic needs of aging spinal cord injured veterans. We support and encourage the implementation of the provisions of H.R. 505 to provide respite care programs. Additionally, we believe that passage of H.R. 505 would enhance such studies by including the needs of the aging SCI veteran. We believe that positive approaches to non-institutional care such as respite care programs will demonstrate the need to provide differing health care extension programs for all veterans. PVA is supportive of H.R. 505, but, would strongly advise and urge the Chairman that implementation of the "Respite Care" program should include younger as well as the "older catastrophically disabled" service and nonservice-connected veterans.

In providing respite care we are aware that such a program will have different meanings for the different needs of different people. However, to repeat, the overall concept and need of a respite care program is what is important and one that we support, if amended appropriately to include both service-connected and nonservice-connected severely disabled veterans.

PVA also supports Section 6 of H.R. 505 which would provide an increase in the number of the VA's Geriatric research, education, and clinical centers (GRECC's). The importance of this worthwhile program to study the needs of aging veterans is clearly recognizable. Again, PVA believes this program, established by Congress in Public Law 96–330, should require the Veterans Administration to become involved in, and that the research study should include, the needs of the aging spinal cord injured veteran.

We support the need to increase the present authorized level of 15 GRECC's to 25 centers, but would request that this occur with the VA's inclusion of studying the needs of the aging SCI veterans. VA programs to address these needs must begin to

take shape and be provided in a meaningful manner. PVA, therefore supports the legislation, H.R. 505, the "Older Veterans' Health Care Amendments of 1985," as one answer to this complex problem of providing care for the nation's long-term disabled as well as the aging veteran.

PVA would like to thank the Members and staff of this Subcommittee for allowing us to discuss these important issues under consideration at this time. This concludes my statement Mr. Chairman and I will be glad to answer any questions that I can.

STATEMENT BY NATIONAL PRESIDENT THOMAS MILLER, BLINDED VETERANS ASSOCIATION

Mr. Chairmen and members of the committees, I am very pleased to submit this testimony and present the views of the Blinded Veterans Association (BVA) on health care issues affecting the older veterans population.

The Blinded Veterans Association is an organization concerned with the welfare of America's blinded veterans. Our membership includes those veterans who lost their vision as a result of injuries incurred while in service. The BVA has a separate associate membership category for veterans who have lost their sight as a result of non-service-connected conditions.

Founded in 1945 and chartered by Congress as the official representative of blinded veterans, the BVA celebrates this year its fortieth anniversary of providing services and assistance to blinded veterans throughout the nation. Our programs and services have one common thread; that is, we believe that blinded veterans are in a unique position to help their fellow blinded veterans in need. This is the essence of the BVA and the philosophy which has engineered the BVA's development and public policy program over the years.

We are very pleased that his hearing and the hearing on April 23 were scheduled. As the members of the Subcommittee on Hospitals and Health Care know, the BVA recommended in late February during our annual presentation before the House and Senate Committees on Veterans Affairs that the committee hold joint hearings with the House Select Committee on Aging. We are very pleased that Chairman Edgar has moved so expeditiously on that recommendation.

The concern which we expressed in late February as part of our annual statement is as true today—several months into the budget debate—as it was then. We are deeply concerned that the Veterans Administration and this Congress are operating in a vacuum as they consider issues relating to the aging veterans population. This hearing is a positive step in recognizing that health care issues affecting older veterans must be addressed within the context of the government's overall aging policies.

This vacuum of which we speak was no more evident than in the recent budget message for FY 86 submitted by the Reagan administration. In addition to calling for sharp cutbacks in the VA's medical and construction program and proposing to restrict eligibility for VA health care, the budget proposed a $25.8 billion cut in Medicare and Medicaid over the next three years. Government budget forecasters, however, failed to provide any documentation on the impact on the veterans population of this double barrel cut. Many today in the executive branch and also the Congress argue that veterans health care programs can withstand cutbacks because other federal health care programs are available for everyone's use. These programs are Medicare and Medicaid. Yet, those who rely solely on these programs also are being told that they must withstand government reductions and bear a greater burden for their medical expenses.

The BVA wants to ensure that older veterans who are in need of health care will have such care available to them regardless of their economic condition. Medical expenses for America's aging population are staggering; the percentage of an older person's annual income committed to medical expenses is even more staggering. Nearly 20 percent of an older person's annual income is spent on health care. Thirty percent of citizens over 65 in this nation fall below a $7500 annual income level. The financial burden on America's older population is fast becoming more unbearable because they are being asked to pay a greater share of their medical expenses—medical expenses over which they have no control.

Over the last four years, reductions in Medicare have resulted in growing deductibles for citizens over 65. Reductions in Medicaid also have left a mark on health care in this nation for the poor and disadvantaged. We do not believe the VA should be in the business of replicating this type of economic and health care disaster.

The argument is made by some that medical care is just too expensive and that people must begin to accept that they must pay a greater share of their medical expenses. Supposedly, these free market conditions will encourage the medical pro-

fessions to impose tighter regulations on themselves in an effort to control costs and discourage wasteful spending. The victim in any such situation, however, is the person who needs medical care services or who relies on a medical professional to ensure their well-being. Clearly, health care financing in this nation is the single most important problem confronting citizens over 65, and it is clearly an issue of vital importance to the government and the insurance industry. However, citizens in need of medical care cannot be expected to bear the financial burden of regulating the medical profession. Nor should they be expected to bear the expense of an insurance industry windfall.

The VA health care system is the single most important benefit available to this nation's veterans. In recent years, veterans groups have not had to preoccupy themselves with thoughts on health care for our aging veterans because veterans over 65 are eligible for free VA health care, according to current law. Recognizing the impact of such law, however, the VA has been seeking to address in recent years the question of providing services to veterans over 65 and the resultant economic cost. We learned this year of the proposed solution and the only label we can apply to this solution is one rampant with extreme cynicism. A great deal of attention was focused last year on a long-delayed report from the VA called "Caring for the Older Veteran". Originally, this report was to be a comprehensive assessment of the VA's capacity to deliver health care services to all veterans. As the report's date for publication was continually delayed, official announcements indicated that the report would not be as specific as originally conceived. Once the report was finally released last summer, it became apparent that the report was indeed a very general statement and did not offer the hope for the future which had been generated months earlier.

The budget submitted to Congress by the VA demonstrates the VA's thoughts on providing health care services for older veterans. It seeks to limit eligibility by deleting from current law the provision making veterans over 65 eligible for free Va health care. In other words, the VA recognizes it cannot handle the problem under existing financial constraints. So, where are such veterans to go for health care? To Medicare and Medicaid, some in government say. So, budget reductions and budget freezes are proposed in all health care programs—those for veterans and non-veterans. Ensuring proper health care, then, seems no longer a priority for the federal government.

The BVA feels very strongly that the government cannot point to a true cost savings by restricting VA eligibility and moving needy veterans into other government health care programs. OMB's arguments to the contrary simply are not logical.

In fact, government reductions in Medicare and Medicaid are likely to increase the demand for VA health care services among the older veterans population. In the April 1985 issue of VA Practitioner, Harry Schwartz, a well-known and respected health care journalist writes:

"Many of those who have hitherto pooh-poohed the idea that the VA medical system would have to be expanded in the era of rapidly growing numbers of veterans 65 and older have done so on the assumption that Medicare and Medicaid would be available and would provide most of the needed safety net for veterans who have become senior citizens. All of a sudden that safety net looks as though it needs its own safety net. Put another way, the planned deterioration of Medicare and Medicaid must make the VA a more desirable alternative for a significant number of veterans who in earlier years would never have thought of looking to the VA for medical care."

Reductions, annual freezes, and restrained initiatives in aging-related VA health care planning and spending will only mean that more older veterans will not have quality medical care available to them. The health care spending policies of the VA will create severe financial hardships for veterans aged 65 and over who will be in need of health care, especially for those veterans who might be in need of specialty-type services.

The means test, itself, proposed by the VA will also cause undue financial burdens on veterans, and it will hit the most vulnerable population—those 65 and older—most severely—if the VA is successful in changing eligibility for those 65 and older. 1979 legislation mandated a means test for veterans under age 65; yet, the VA has never developed such a test. This, itself, is testimony to the difficulty in developing a fair test. The test now proposed by the VA establishes $15,000 as the annual income level in which a veteran would begin to contribute to his health care costs. This level of income is not very high especially when considering the costs of health care. If this same means test were to apply to veterans over 65, it would represent a financial disaster for many.

The BVA also is very concerned with the implementation of some other cost savings techniques proposed in recent years within the VA. The BVA is not convinced that the implementation of DRG's and PRO's within the VA is appropriate at this time. Both DRG's and PRO's have been very controversial within the health care professions. There is not a universal sentiment that either one results in any cost savings and there is some genuine concern among health professionals that these management tools work to the detriment of diagnosis and treatment.

We are especially concerned with the DRG concept and its effect both on aging veterans in general and more specifically its effect on blinded aging veterans and veterans with severe visual impairments. The essence of the DRG is to establish a medical model of care. Such models do not allow room for special disabilities and their effect on healing, preventive health care, and health maintenance. This is especially true with regard to rehabilitation programs. More specifically, these programs should be permanently exempt from DRG application.

It is important to note that management tools such as DRG and PRO's, are just that—management tools—the means used by administrators to control costs. The BVA is not opposed to controlling costs of health care, but we do not advocate abandoning the physical well-being of a patient in order to save money. There is wide disagreement between medical professionals responsible for the day to day care of patients and medical administrators responsible for the day to day financial operations on the value of DRG's and PRO's. What is of most concern to us concerning the VA's implementation of the DRG concept is that future funding levels for hospitals will be based on the DRG models and not actual usage of VA facilities. This could have the effect of further budget reductions in VA health care because the population profile utilizing VA hospitals—i.e. older veterans—are not consistent with some of the basic health care utilization models for non-VA hospitals.

The BVA is also strongly opposed to the proposal offered by the VA to require reimburement by private insurance for services provided within the VA. We believe this establishes a dangerous precedent. First, there will be more pressure put on older veterans to purchase medical insurance when they might not be able to afford it. Fear that the VA might reduce services to them now or sometime in the future could be the incentive to such veterans to purchase medical insurance at substantial cost creating an additional financial burden on them while providing a boom to the insurance industry. Second, such a proposal would establish the basis for cost sharing in the VA and could eventually lead to the dismantling of the VA system. Once cost sharing is established within VA hospitals, hospital administrators in non-VA hospitals would put more pressure on Congress and the executive branch to allow for direct VA reimbursement for veterans receiving care in non-VA hospitals. Many non-VA hospital administrators salivate at the prospect of a massive new group of consumers who will be in need of medical care, this being the aging veterans population. They would be eager to fill their empty hospital beds with veterans and then have the VA pay the bills.

The VA, then, will lose control over health care for veterans and it will lose its mission as the agency providing for the care of our nation's veterans. The VA system has long been viewed as the most cost-effective health care provider in the nation. Once veterans are treated on a wholesale basis outside the VA system, costs to deliver health care services will increase dramatically. If current proposals are any indication, then, it would seem likely that veterans would be asked to bear again a greater share of their health care costs. It could then just be a matter of time until the VA would provide certain allowances for veterans to receive health care and veterans would be expected to pay the balance of their health cost expenses.

Currently, the hallmark of the VA programs for aging veterans is the Geriatric Research Education Clinical Centers (GRECC). Currently, legislation enables the VA to operate fifteen such centers. It now operates ten GRECC's throughout the country. The GRECC concept is designed to increase VA health professional's understanding of aging by conducting research, and interpreting, applying, and disseminating new and existing knowledge about geriatrics and gerontology. The GRECC programs serve as clinical sites for the education of health care professionals as well as settings for health services research and biomedical studies which deal with aging. We commend the VA for developing such an innovative program.

However, we strongly recommend that additional funding for GRECC's should be allocated to projects concerned with blindness, visual impairment, and the visual system. The lack of such research and education is a substantial drawback of the GRECC program.

The BVA testified in Congress recently that there is a vast pool of knowledge now available within the VA for the rehabilitation of veterans who lose their vision trau-

matically. However, very little is known today about the needs—either biomedical, psychosocial, or rehabilitative—of those veterans who slowly witness the erosion of their visual functional abilities. Additionally, we do not really know what impact the aging process might have on the psychosocial needs of veterans who have traumatically lost their vision as a result of service-connected injuries. Medical personnel require training to work with both groups. What is important to note, however, is that we are speaking of two separate populations with substantially different needs.

Geriatric research related to blindness and visual impairment has not been a major priority for the VA. The BVA believes very strongly that one GREC Center could provide a focus for geriatric research related to blindness and visual impairment. Two of the existing centers would be ideal locations for such research. A Blind Rehabilitation Center is located in Palo Alto and a Blind Rehabilitation Clinic operates at American Lake. GRECC's are established at both locations.

Blinded veterans and veterans with deteriorating visual abilities are not helpless. On an everyday basis, the BVA fights the notion that the blind and visually impaired are helpless. Such individuals are helpless only if they are abandoned and programs for rehabilitation and adjustment denied. With rehabilitation, there is little that a blind or visually impaired person cannot do. The VA has been diligent in establishing rehabilitation programs for those of us who traumatically lose our sight. However, the demands are greater now than ever before and this new population of veterans gradually losing their vision is growing substantially. New and innovative programs are required. Training is needed for medical staff, so that they too can contribute to the rehabilitation process.

This is a role for the VA GRECC program. We strongly encourage this subcommittee to work with us in obtaining funding for blindness-related projects at an existing GREC Center or a newly funded center. Such research will not only benefit all those veterans in need of care, but the knowledge and models for rehabilitative care developed as a result of such research can be applied to the non-veterans population as well. We also support the provisions of H.R. 505 introduced by Congressman Edgar which would increase the number of GREC Centers now allowed under current law from fifteen to twenty-five. This is a step in the right direction—a recognition that more needs to be done for our aging veterans population. However, this Congress must take prompt action to get the VA to recognize that it must make special provisions for the conduct of research initiatives dealing with special populations of veterans, such as blinded and visually impaired.

The VA must soon recognize that the aging population will result in a greater precentage of problems related to the visual system. The VA has recognized, for example, that dentistry is a vital concern of the aging population. However, the VA does not seem to place the same priority on the visual needs of our older veterans. All one has to do is read the VA's report on aging, "Caring for the Older Veterans" to verify this. The Inventory of Programs and Services listed in the section on the Department of Medicine and Surgery (pages 38–57) does not even mention blind rehabilitation, the visual system, or blindness. Yet, there are special sections on Medical and Surgical Treatment, Mental Health Care, Dental Care, Physical Rehabilitation, Nutrition, and Recreation—just to mention a few. But, what about visual health; is this not important, too?

Additionally, the VA must increase its outreach efforts to blinded and visually impaired veterans and develop rehabilitation programs with emphasis on home and community care.

There should be a more appropriate means to respond to the needs which are now beginning to emerge than the rigorous programs available at the VA's Blind Rehabilitation Clinics and Centers. Such veterans could benefit more from training in their home, especially those veterans with memory problems resulting as part of the aging process. They also would be able to relate their training to their home environment, whereas, memory lapses could prevent them from transferring the results of their training from as clinic environment to their home surrouding. It is important also to remember that the older someone is, the less willing they are to leave their home and travel to a strange city for any type of care—let alone a program of blind or low vision rehabilitation. To many such veterans, their home is their protection—their last bastion of comfort and security. Many could fear a permanent loss of their security if they leave their home environment.

Additonally, the VA's outreach efforts to older blind and visually impaired veterans must be expanded dramatically because the agency cannot be satisfied that a need does not exist if veterans, themselves, are not knocking down the VA's medical center doors. We ourselves know from our own experiences of working with blinded veterans that the loss of sight can be a very emotional, shattering, and isolating experience. In reality, the experience can be worse for someone whose visual loss is a

gradual one which can be denied over the years. That is, until the gradual loss is a total functional loss or seems to be so severe as to prevent that individual from living independently or even living at all. We must ensure that such veterans realize that such a loss need not affect their ability to live independently. But, in order to do this, the VA must expand its outreach efforts, and it must provide for facilities in communities which allow veterans easy access to rehabilitation programs.

As an expanded outreach program identifies older blinded and visually impaired veterans in need of rehabilitation, rehabilitation teachers also could be added to the staffs of field stations. Because the blind rehabilitation centers and clinics will not be adequate or appropriate, in some instrances, to handle the influx, the rehabilitation teacher is a means to provide a cost-effective service locally to assist older blinded and visually impaired veterans to become independent in their home communities.

By providing an opportunity for rehabilitation in the community, itself, older blinded veterans will be able to remain in their homes for a longer period of time without need for nursing home care.

Additionally, the VA must examine the need to develop a low vision program within its nursing homes and domiciliaries. The number of Visual Impairment Centers to Optimize Remaining Sight, a special low vision program within the VA designed to provide assistance to veterans with visual handicaps not as severe as legal blindness, should be increased. And the number of central-office funded full time coordinators for the VA's Visual Impairment Service Teams should be increased. (Currently, there are only 37 central-office funded full time coordinators for 81 VIS Teams.)

For some reason, all Americans tend to neglect their visual system. Those of us who are blind can think back to earlier days when we, ourselves, failed to recognize the importance of adequate vision health. Our visual system is as much a part of overall health care as any other body organ. We must not lose sight of the practical day applications of rehabilitative care which are necessary for someone who is blinded and visually impaired. Too often, the medical profession views blindness and visual deterioration as failures of modern medicine; it is much more fun to marvel at such procedures as artificial heart surgery rather than to conduct research and apply its findings to the day to day mobility of someone who is visually impaired and over 65. Too often, we ignore the basics and favor the sensational. There is a great deal yet to be done for our population of older veterans and the VA is the ideal place to begin.

The veterans population is a captive population. It is for this reason that research efforts in the VA have such potential and that the VA traditionally has been at the forefront of rehabilitative research. The potential is so great that it seems even more frustrating that the agency and the government as a whole are beset with the need to balance this potential against spending deficits.

There should be no higher priority in this nation than caring for our older citizens. The VA has an opportunity to contribute substantially to the research and knowledge and health care services required by this group. Obviously, the administration is not now prepared to commit the resources necessary to respond to these challenges. This places a greater burden on Congress, especially those committees concerned with aging-related issues, to take the necessary steps to respond to people's needs—both now and for the future.

This hearing is an excellent step in that direction. Congress, as a whole, must help to provide direction on some of these concerns; more hearings need to be held; more hearings need to be held throughout the nation to hear from older Americans of the impact of aging on their lives and their needs for medical care within their own communities.

Again, thank you for this opportunity to present the views of the BVA and I will be happy to respond to any questions you might submit to me in writing.

THOMAS H. MILLER,
National President and
Chairman of the Board.

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